

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

10106

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10117

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) ELSIE V ABELL			2a. DATE OF DEATH 7 Month 16 Day 68 Year			2b. HOUR 11:30 AM			
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MAY 17-1888		6. AGE (In years last birthday) 80 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH MONTGOMERY Md.			
10. CITY OR TOWN OF DEATH SILVER SPRING		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) BELLA VISTA NURSING HOME		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD		13b. COUNTY MONTG		13c. CITY OR TOWN TAKOMA PARK		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 8006 GREENWOOD AVE	
14. FATHER'S NAME First Middle Last GRANVILLE			15. MOTHER'S MAIDEN NAME First Middle Last HARTING KATHERINE WILLIAMS						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 219 54 0654T		17. INFORMANT MILDRED HAUGH		Address 79016 GREENWOOD AVE TAKOMA PARK			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 4129 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) A.S.H.O. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 Hr 3 Yrs									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4200 Diabetes Mellitus									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 9/15/67 , 19 67 , to 7/15 , 19 68 , that (I) (we) last saw the deceased alive on 9/15/71/68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Donald Neugebauer MD DEGREE				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 7/16/68			
22d. PHYSICIAN'S NAME (Type) Dr. D. Neugebauer				22e. ADDRESS 5415 Cornhill Ave NW					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE July 19-1968		23c. NAME OF CEMETERY OR CREMATORY Union Cemetery		23d. LOCATION (City or Town) County State Baltimore Montgomery Md			
24. FUNERAL DIRECTOR Arthur Walters		ADDRESS 254 Cornhill St		24a. REC'D BY REGISTRAR JUL 18 1968		24b. REGISTRAR'S SIGNATURE Charles Judge			



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10107		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				10118	
Item #4, Film G403 8/5/68 km							
1. DECEASED NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year	
SARA			None		ABRAMSON	7 27 68	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years lost birthday)	
FEMALE		HEB White		11-15-84		83 YRS.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH	
RUSSIA		AMERICAN				MONTGOMERY Md.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
TAKOMA PARK		WASHINGTON SAN & Hosp		HOUSEWIFE			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
DC				Washington		13e. STREET AND NUMBER	
						1441 SOMMERSET PL.	
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME	
LOUIS					MARKMAN	EVA	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO.		17. INFORMANT			
No		UNKNOWN		CHART			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4339 thrombosis left middle cerebral artery DUE TO, OR AS A CONSEQUENCE OF (b) cerebro-vascular arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 40 days years.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 332X							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from about 1953 to 1-27-1968, that (I) (we) last saw the deceased alive on 1-26-1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE JACK J. RHEINGOLD M.D.				DEGREE M.D.		22c. DATE SIGNED 7/27/68	
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS			
JACK J. RHEINGOLD M.D.				1100 22nd St. N.W. WASH DC.			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)	
BURIAL		7-28-68		NATH MEMORIAL PARK		FALLS CHURCH VA.	
24. FUNERAL DIRECTOR				ADDRESS		25a. REC'D BY REGISTRAR	
GOLDBERG FUNERAL HOME 4517 9TH ST. N.W.						25b. REGISTRAR'S SIGNATURE Charles Judge	
				DATE		JUL 31 1968	

11-11-11

question - what is the difference between
 a good and a bad person?
 A good person is one who is
 kind, honest, and helpful.
 A bad person is one who is
 cruel, dishonest, and selfish.
 The difference is in the heart.
 A good heart leads to good actions,
 and a bad heart leads to bad actions.
 We must strive to have a good heart,
 for it is the source of all goodness.

10108

CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) CHARLES B			First Middle Last			2a. DATE OF DEATH Month Day Year July 27, 1968			2b. HOUR 8:50 PM		
3. SEX Male			4. RACE White			5. DATE OF BIRTH 5-18-82			6. AGE (In years last birthday) 86 YRS.		
7a. BIRTHPLACE (State or foreign country) Indiana			7b. CITIZEN OF WHAT COUNTRY? U. S. A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Montgomery Md.		
10. CITY OR TOWN OF DEATH Silver Spring			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Wash. San. & Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Retired Baseball Player			12b. KIND OF BUSINESS OR INDUSTRY Pirates		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.			13b. COUNTY Montgomery			13c. CITY OR TOWN Sil. Spring			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
13e. STREET AND NUMBER 17 Parkside Rd.			14. FATHER'S NAME First Middle Last Samuel Adams			15. MOTHER'S MAIDEN NAME First Middle Last Nancy Tower					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <input checked="" type="checkbox"/> No			16b. SOCIAL SECURITY NO. 499-22-7736 A			17. INFORMANT Elizabeth Denham - Daughter			17 Parkside Rd. S. S. Md. Same address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory arrest 150X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Extremely severe malnutrition DUE TO, OR AS A CONSEQUENCE OF (c) Complications of Carcinoma of Esophagus APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 Hours 2 years 6-7 Months											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 150X Extension of primary Ca of Esophagus											
19a. DATE OF OPERATION Dec 1965			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Carcinoma of Esophagus			20a. AUTOPSY YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from Dec 1965 , to July 26, 1968 , that (I) (we) last saw the deceased alive on July 26, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Wilford D. Meyers MD						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED July 27, 1968		
22d. PHYSICIAN'S NAME (Type) Wilford D. Meyers MD						22e. ADDRESS 8323 Haddon Drive Takoma Park, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation			23b. DATE July 30, 1968			23c. NAME OF CEMETERY OR CREMATORY St. Lincoln Crematory			23d. LOCATION (City or Town) (County) (State) Prince Georges Co. Md.		
24. FUNERAL DIRECTOR Warner E. Pumphrey, Inc. Silver Spring, Md.						25a. REC'D BY REGISTRAR AUG 1 1968			25b. REGISTRAR'S SIGNATURE Charles Judge		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) Roger Dean Adams			2a. DATE OF DEATH Month July Day 17 Year 1968			2b. HOUR 10:00 AM			
3. SEX Male		4. RACE White		5. DATE OF BIRTH 26 March 1951		6. AGE (In years last birthday) 17 YRS.		IF UNDER 1 YEAR MONTHS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Ohio		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.			
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) The Clinical Center, NIH		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Student		12b. KIND OF BUSINESS OR INDUSTRY None			
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE California		13b. COUNTY Anaheim		13c. CITY OR TOWN Anaheim		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 12272 Orangewood Avenue	
14. FATHER'S NAME First Middle Last Shirley M. Adams			15. MOTHER'S MAIDEN NAME First Middle Last Emma Beacher						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. 552-82-9476		17. INFORMANT The Medical Record Address The Clinical Center, NIH, Bethesda, Maryland				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pseudomonas sepsis 2029 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Burkitt's lymphoma DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 days 12 months									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 2021									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 7 May , 1968, to 17 July , 1968, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 17 July , 1968, and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) <input checked="" type="checkbox"/> view the body after death.									
22b. SIGNATURE Sherrard L. Hayes, M.D.				DEGREE MD		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 17 July 1968	
22d. PHYSICIAN'S NAME (Type) Sherrard L. Hayes, M. D.				22e. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 20 JULY 1968		23c. NAME OF CEMETERY OR CREMATORY WESTMINSTER CALIFORNIA		23d. LOCATION (City or Town) (County) (State)			
24. FUNERAL DIRECTOR RINALDI FUNERAL HOME		ADDRESS 7400 GEORGIA AVE NW		25a. REC'D BY REGISTRAR JUL 19 1968		25b. REGISTRAR'S SIGNATURE J. Charles Young			

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IN SENATE, JANUARY 14, 1908.

REPORT OF THE COMMISSIONERS OF THE LAND OFFICE.

ALBANY: JAMES BRONKHORST, STATE PRINTER, 1908.

THE COMMISSIONERS OF THE LAND OFFICE HAVE THE HONOR TO ACKNOWLEDGE THE RECEIPT OF THE FOLLOWING:

THE LAND OFFICE HAS RECEIVED THE FOLLOWING:

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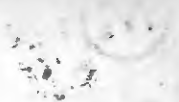
THE LAND OFFICE HAS RECEIVED THE FOLLOWING:

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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) Daniel M. Adcock						2a. DATE OF DEATH Month 7 Day 19 Year 68		2b. HOUR 7 A	
3. SEX Male		4. RACE White		5. DATE OF BIRTH 4-10-27		6. AGE (In years lost, birthday) 41 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.			
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Suburban		12a. USUAL OCCUPATION (Kind of work done during most of working life, when if retired.) Plumber		12b. KIND OF BUSINESS OR INDUSTRY Contractors			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Mont.		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 1501 Gleason St.	
14. FATHER'S NAME First Willis Middle L. Last Adcock			15. MOTHER'S MAIDEN NAME First SARA Middle ANN Last Adcock						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <input type="checkbox"/>			16b. SOCIAL SECURITY NO.		17. INFORMANT BEATHER Address DAMASCUS MD Ray - M Adcock - 10611 SURREY ST. RD				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cardio pul insuff 1621 DUE TO, OR AS A CONSEQUENCE OF: Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) extensive a P. by DUE TO, OR AS A CONSEQUENCE OF: (c) status post op of B. pneumonia									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) 163X									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from Mar 21, 1968 to July 16, 1968 , that (I) (we) lost the deceased alive on July 18, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.									
22b. SIGNATURE D.C. Adcock (MD) DEGREE				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 7/19/68			
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS 1234 19th NW Wash DC.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE July 21, 1968		23c. NAME OF CEMETERY OR CREMATORY Glendale Methodist		23d. LOCATION (City or Town) Buckingham Co., (County) Virginia (State)			
24. FUNERAL DIRECTOR Walter J. Holt				ADDRESS Cunningham Funeral Home Inc. Alex., Va.		25a. REC'D BY REGISTRAR JUL 23 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	



[Faint, mostly illegible handwritten text covering the majority of the page. The text appears to be organized into several horizontal lines, possibly representing a list or a series of entries.]

[Faint, mostly illegible text at the bottom of the page, possibly a footer or a concluding note.]

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PH-3. Pages 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
10M REV 1-68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or Print) <i>Frederick</i>		First <i>III</i>		Middle <i>Alber</i>		Last		2a DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> Month <i>July</i> Day <i>5</i> Year <i>1968</i>		2b HOUR <i>8:20</i> AM		
3 SEX <i>male</i>	4 RACE <i>white</i>	5 DATE OF BIRTH <i>July 1, 1904</i>		6 AGE (in years last birthday) <i>64</i> YRS	IF UNDER 1 YEAR MONTHS <i>0</i> DAYS <i>0</i>		IF UNDER 24 HRS HOURS <i>0</i> MIN <i>0</i>		2c DATE PRONOUNCED DEAD Month <i>July</i> Day <i>5</i> Year <i>1968</i>		2d HOUR <i>8:20</i> AM	
7a BIRTH-PLACE (State or foreign country) <i>Washington, D.C.</i>		7b CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <i>Montgomery</i>						
10 CITY OR TOWN OF DEATH <i>Silver Spring</i>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Holy Cross Hospital</i>				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Automobile Service Manager</i>			12b KIND OF BUSINESS OR INDUSTRY			
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <i>Maryland</i>		13b COUNTY <i>Simpsonville</i>		13c CITY OR TOWN <i>Simpsonville</i>		13d INSIDE CITY, A.M. 157 <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e STREET AND NUMBER <i>217 Groveleigh Drive</i>				
14 FATHER'S NAME First <i>Frederick</i> Middle <i>Alber</i> Last <i>Alber</i>		15 MOTHER'S MAIDEN NAME First <i>Lauretta</i> Middle <i>Martin</i> Last <i>Martin</i>		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> (If yes give war or dates of service)		16b SOCIAL SECURITY NO <i>578-09-8092</i>		17 INFORMANT <i>Mrs. Edith L. Alber</i>		ADDRESS <i>Simpsonville, Md.</i> <i>217 Groveleigh Drive</i>		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Asphyxia from hemorrhage from Throat. Sudden.</i> <i>511</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Bronchial Fibrosis & Parkinson Syndrome.</i> years <i>5</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>511</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost <i>511</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Fracture of Left Femur</i>												
9a DATE OF OPERATION <i>3 May 1968</i>		19b CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Left Hip Nailed</i>		20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year HOUR A.M. <i>5:30</i> P.M. <i>3</i> 1968		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) <i>Fall at home causing Fracture. Hip.</i>								
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <i>Home</i>		21f LOCATION Street or R.F.D. No <i>217 Groveleigh Drive</i> City or Town <i>Simpsonville</i> County <i>Md.</i> State <i>Md.</i>								
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE <i>John G. Ball</i>		EXAMINER'S NAME (Type) <i>John G. Ball</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED <i>July 5, 1968</i>		
23a BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b DATE <i>July 8, 1968</i>		23c NAME OF CEMETERY OR CREMATORY <i>St. Lincoln Cemetery</i>		23d LOCATION (City or Town) <i>Prince George Co., Md.</i>		(County)		(State)		
24 FUNERAL DIRECTOR <i>Warner E. Pumphrey, Inc.</i>		25a ADDRESS <i>8434 Georgia Avenue Silver Spring, Md.</i>		25b REC'D BY REGISTRAR DATE <i>JUL 10 1968</i>		25c REGISTRAR'S SIGNATURE <i>Charles Judge</i>						

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. These pages remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal. In any event, within 72 hours after death

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED NAME (Type or print) First Middle Last Thomas A. ALLDREDGE			2a. DATE OF DEATH Month Day Year July 29 68			2b. HOUR 1220AM			
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH Dec. 25, 1915		6. AGE (In years last birthday) 52 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Alabama		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md			
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Naval Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) U. S. Navy		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland		13b. COUNTY Lexington Park		13c. CITY OR TOWN Lexington Park		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 127 Holly Road	
14. FATHER'S NAME First Middle Last James Alldredge			15. MOTHER'S MAIDEN NAME First Middle Last Lola Vanzant						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16b. SOCIAL SECURITY NO (If yes give war or dates of service) 557-14-4611		17. INFORMANT Mrs. Patricia Alldredge, 127 Holly Rd., Lexington Park Address Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinoma of the pancreas, recurrent, with metastases</u> 14 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 157X									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <u>June 17</u> , 19 <u>68</u> , to <u>July 29</u> , 19 <u>68</u> , that (I) (we) lost saw the deceased alive on <u>July 29</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death.									
22b. SIGNATURE <u>T. A. Maclean</u>					DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (Type) T. A. MACLEAN					22e. ADDRESS Naval Hospital, Bethesda, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 8-1-68		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City or Town) (County) (State) Arlington, Virginia			
24. FUNERAL DIRECTOR <u>Robinson Funeral Home</u> ADDRESS Leonardtwn, Maryland					25a. REC'D BY REGISTRAR AUG 1 1968		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED NAME (Type or print) First Middle Last <i>Astrid Evangeline Anderson</i>					2a. DATE OF DEATH Month Day Year <i>July 22, 1968</i>		2b. HOUR <i>2:00 PM</i>		
3. SEX <i>Female</i>		4. RACE <i>white</i>		5. DATE OF BIRTH <i>January 1, 1903</i>		6. AGE (In years last birthday) <i>65</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <i>Somerville, Mass.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i> Md.			
10. CITY OR TOWN OF DEATH <i>Silver Spring</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Retired Clerk-Typist</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>U.S. Govt.</i>		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <i>Maryland</i>		13b. COUNTY <i>Montgomery</i>		13c. CITY OR TOWN <i>Silver Spring</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>1576 East-West Highway</i>	
14. FATHER'S NAME First Middle Last <i>Peter Johnson</i>			15. MOTHER'S MAIDEN NAME First Middle Last <i>unknown</i>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) <i>No</i>		16b. SOCIAL SECURITY NO <i>yes</i>		17. INFORMANT Address <i>Mr. George W. Anderson, 1576 East-West Hwy.</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Multiple pulmonary metastases, bilateral, endometrial carcinoma</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Primary endometrial carcinoma</i> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>8 months</i> <i>15 months</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
MEDICAL CERTIFICATION									
19a. DATE OF OPERATION <i>July 19, 1967</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Endometrial carcinoma</i>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from <i>May 4, 1967</i> , to <i>July 22, 1968</i> ; that (I) (we) lost saw the deceased alive on <i>July 19, 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death									
22b. SIGNATURE <i>George L. Ball</i>				DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <i>July 22, 1968</i>			
22d. PHYSICIAN'S NAME (Type) <i>George L. Ball</i>				22e. ADDRESS <i>10620 Georgia Ave Silver Spring, Md.</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>July 25, 1968</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Parklawn Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Rockville, Montg. Md.</i>		25a. REC'D BY REGISTRAR <i>JUL 29 1968</i>	
23e. ADDRESS <i>C. Glen Carter Warner E. Pumphrey, Inc. Silver Spring, Md.</i>				25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH																	
1 DECEASED NAME (Type or Print)			First DANA			Middle FOSS			Last ANGIER			2a DATE KNOWN OF DEATH Month 7- Day 6- Year 68		2b HOUR 11:05 AM			
3 SEX M		4 RACE W		5 DATE OF BIRTH 10-12-75 10-19-1875		6 AGE (in years last birthday) 92 YRS.		7 UNDER 1 YEAR MONTHS DAYS		7 UNDER 24 HRS HOURS MIN.		2c DATE PRONOUNCED DEAD Month 7- Day 6- Year 68		2d HOUR 1:05 PM			
7a BIRTHPLACE (State or foreign country) ILLINOIS				7b CITIZEN OF WHAT COUNTRY? U. S. A.				8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9 COUNTY OF DEATH MONTGOMERY					
10 CITY OR TOWN OF DEATH TAKOMA PARK				11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) WASHINGTON SANITARIUM				12a USUAL OCCUPATION (Kind of work done during last 12 months, even if retired) POST OFFICE				12b KIND OF BUSINESS OR INDUSTRY					
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MD.				13b COUNTY				13c CITY OR TOWN TAKOMA PARK				13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 7311 Maple Ave.			
14 FATHER'S NAME First Middle Last FRANKLIN LUTHER ANGIER						15 MOTHER'S MAIDEN NAME First Middle Last ADELINE											
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or unknown) NO				16b SOCIAL SECURITY NO.				17. INFORMANT Mr. John Cope -- Son in law									
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia - Bronchial</u> 440.4 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Malnutrition + Emaciation</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arterio Sclerosis - generalized -</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 440.4												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days					
19a DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19				21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)									
21a INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f LOCATION Street or R.F.D. No City or Town County State									
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																	
ACTUAL SIGNATURE EXAMINER'S NAME (Type) John S. Bill				M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county)				22b DATE SIGNED July 6, 1968					
23a BURIAL/CREMATION REMOVAL (Specify) Burial				23b DATE July 9-1968				23c NAME OF CEMETERY OR CREMATORY Seelye Washington				23d LOCATION (City or Town) (County) (State) Adelphi Park Md					
24 FUNERAL DIRECTOR Ruth Walters				25a RECD BY REG STRAR JUL 10 1968				25b REG STRAR'S SIGNATURE J Charles Judge									

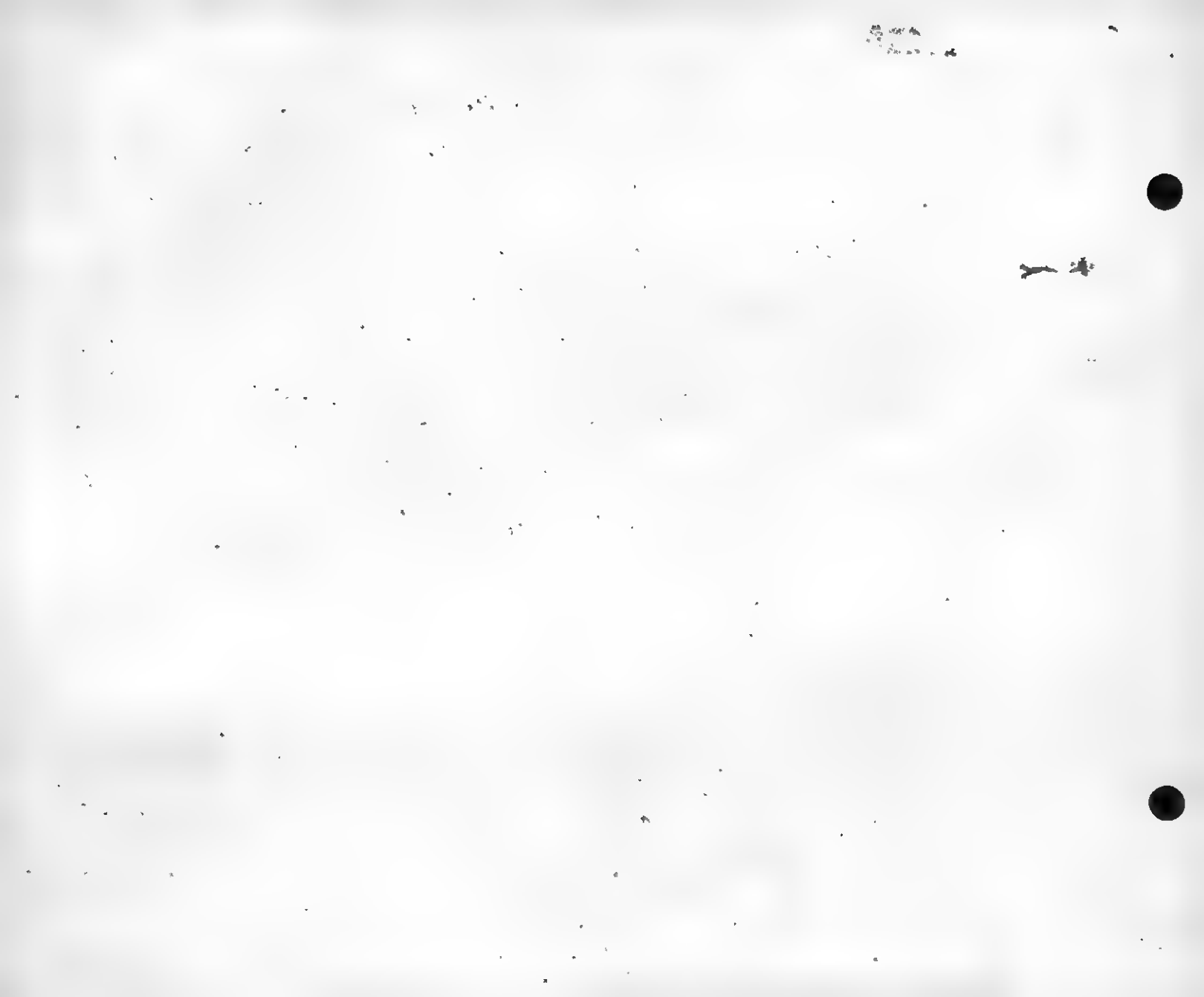


CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) ROTH First D Middle ANTHONY Last			2a. DATE OF DEATH Month July Day 20 Year 1968			2b. HOUR 24 M	
3 SEX Female		4 RACE W		5 DATE OF BIRTH 2/4/15		6 AGE (In years lost birthday) 53 YRS.	
7a. BIRTHPLACE (State or foreign country) Eastern Mass		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md	
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Suburban		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md		13b. COUNTY Mont		13c. CITY OR TOWN Potomac		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 9012 Rouen Lane		14. FATHER'S NAME First Carl Middle DEARDEN Last		15. MOTHER'S MAIDEN NAME First Olivia Middle Aylward Last		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)	
16b. SOCIAL SECURITY NO D-30-09-0960		17 INFORMANT Robert H Anthony		Address 9012 Rouen Lane		City Potomac State Md	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart disease - fulminant DUE TO, OR AS A CONSEQUENCE OF General Aortic DUE TO, OR AS A CONSEQUENCE OF Coronary atherosclerosis CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 12/1/68							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day 30 days
19a. DATE OF OPERATION 6/4/68		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Ca Colon		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <input checked="" type="checkbox"/> (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 7/19/68 to 7/19/68 , that (I) (we) last saw the deceased alive on 7/19/68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Richard C Myers MD.		DEGREE MD.		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 7/20/68	
22d. PHYSICIAN'S NAME (Type) Richard C Myers MD.		22e. ADDRESS 8512 Old Georgetown Rd. Beth. Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 7/22/68		23c. NAME OF CEMETERY OR CREMATORY Puritan Lawn Cem.		23d. LOCATION (City or Town) (County) (State) Peabody Mass.	
24. FUNERAL DIRECTOR Robert A. Pumphrey 7557 Wise Ave. Bethesda Md.				25a. REC'D BY REGISTRAR JUL 24 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. These pages remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print) Reginald W. ARTHUR			2a. DATE OF DEATH Month July Day 21 Year 1968			2b. HOUR 9:00 AM	
3 SEX Male		4 RACE Caucasian		5 DATE OF BIRTH June 20, 1897		6 AGE (In years last birthday) 71 YRS.	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9 COUNTY OF DEATH Montgomery County Md	
10. CITY OR TOWN OF DEATH Bethesda		11 NAME OF HOSPITAL OR INSTITUTION (if not in hosp. tal give street address) Naval Hospital		12a. USJA. OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Washington		13b. COUNTY D.C.		13c. CITY OR TOWN Washington		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 2500 Wisconsin Ave.		14 FATHER'S NAME First William Middle John Last ARTHUR		15 MOTHER'S MAIDEN NAME First Emma Middle M. Last WILHELM			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) Yes (If yes give war or dates of service)		16b. SOCIAL SECURITY NO 336 26 0484		17. INFORMANT John R. Arthur		Address 938A Felton Rd. Key West, Fla.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchogenic carcinoma DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 16							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from July 17, 1968 , to July 21, 1968 , that (I) (we) last saw the deceased alive on July 21, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE R. D. Gaskins				DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 22 July 1968	
22d. PHYSICIAN'S NAME (Type) R. D. GASKINS, M. D.				22e. ADDRESS Naval Hospital, Bethesda, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 7-24-68		23c. NAME OF CEMETERY OR CREMATORY Greenmount Cemetery		23d. LOCATION (City or Town) (County) (State) York, Penn.	
24. FUNERAL DIRECTOR Robert A. Pumphrey				25a. REC'D BY REGISTRAR DMUL 24 1968		25b. REGISTRAR'S SIGNATURE Charles J. ...	
Address 7557 Wisconsin Ave., Bethesda, Md.							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print) <i>Antonia Adele ARUTA</i>			2a. DATE OF DEATH Month <i>7</i> Day <i>9</i> Year <i>68</i>			2b. HOUR <i>5:45</i> AM			
3 SEX <i>Female</i>		4. RACE <i>White</i>		5 DATE OF BIRTH <i>8-26-88</i>		6. AGE (In years last birthday) <i>79</i> YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <i>Italy</i>		7b. CITIZEN OF WHAT COUNTRY? <i>Amer.</i>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <i>Montgomery County, Md.</i>			
10 CITY OR TOWN OF DEATH <i>Takoma Park</i>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Washington Sanitarium & Hosp.</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>OWN HOME</i>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md.</i>		13b. COUNTY <i>Montgomery</i>		13c. CITY OR TOWN <i>Silver Spring</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>900 Keesey Rd.</i>	
14 FATHER'S NAME First <i>LAUTO</i> Middle <i>VENTIMIGLIA</i> Last <i>Lucy</i>		15. MOTHER'S MAIDEN NAME First <i>Smecchidi</i> Middle Last		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <i>no</i> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <i>579-18-9769</i>		17 INFORMANT <i>Husband</i> Address <i>S.S., Md.</i> <i>900 Keesey Rd.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pneumonia</i> <i>174X</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Caf Breast & metastases to lungs</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>& Generalized Carcinomatous</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2-3 days.</i> <i>1 yr.</i>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c) <i>11X AS COB.</i>									
19a. DATE OF OPERATION <i>1/15X</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>AS COB.</i>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <i>Apr. 2, 1968</i> , to <i>July 8, 1968</i> , that (I) (we) last saw the deceased alive on <i>July 8, 1968</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Russell G. Bufalino</i>		DEGREE <i>MD</i>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>July 9, 68.</i>			
22d. PHYSICIAN'S NAME (Type) <i>Russell G. Bufalino, MD.</i>		22e. ADDRESS <i>1429 U. St. W. Silver Spring, Md.</i>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>July 12, 1968</i>		23c. NAME OF CEMETERY OR CREMATORY <i>National Memorial Park</i>		23d. LOCATION (City or Town) (County) (State) <i>Falls Church, Virginia</i>			
24 FUNERAL DIRECTOR <i>W. Lee Jones</i>		ADDRESS <i>8434 Georgia Avenue</i>		25a. REC'D BY REGISTRAR DATE <i>JUL 15 1968</i>		25b. REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

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20118

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

10120

1 DECEASED-NAME (Type or print) Waldo Arthur Racon			2a. DATE OF DEATH Month July Day 6 Year 1968			2b. HOUR 9th. M	
3 SEX Male		4. RACE Cauc.		5 DATE OF BIRTH July 18, 1908		6 AGE in years (last birthday) 59 YRS.	
7a. BIRTHPLACE (State or foreign country) Mass.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.	
10. CITY OR TOWN OF DEATH Rockville		11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) 3 Drake Court		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Retired Manager		12b. KIND OF BUSINESS OR INDUSTRY Hotel	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 3 Drake Court		14. FATHER'S NAME First Major Middle - Last Racon		15 MOTHER'S MAIDEN NAME First Flora Middle - Last Rolton			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) no (If yes give year or dates of service) - -		16b. SOCIAL SECURITY NO. 577-10-6378		17. INFORMANT Mr. Harvey Racon Address 5400 Pignons Road, Rockville, Maryland			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart Attack DUE TO, OR AS A CONSEQUENCE OF arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 hrs							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 231							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 1-2 , 19 52 to July 6 , 19 68 , that (I) (we) last saw the deceased alive on 1-23 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE John S. Rogers				22c. DATE SIGNED July 6, 1968			
22d. PHYSICIAN'S NAME (Type) John S. Rogers				22e. ADDRESS 1919 Seminary Road, Silver Spring, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE July 10, 1968		23c. NAME OF CEMETERY OR CREMATORY St. Lincoln Cemetery		23d. LOCATION (City or Town) (County) (State) Prince George Co., Md.	
24 FUNERAL DIRECTOR Wm. E. Pumphrey, Inc. Address 434 Georgia Avenue, Silver Spring, Md.				25a. REC'D BY REGISTRAR Charles Judge		25b. REGISTRAR'S SIGNATURE Charles Judge	



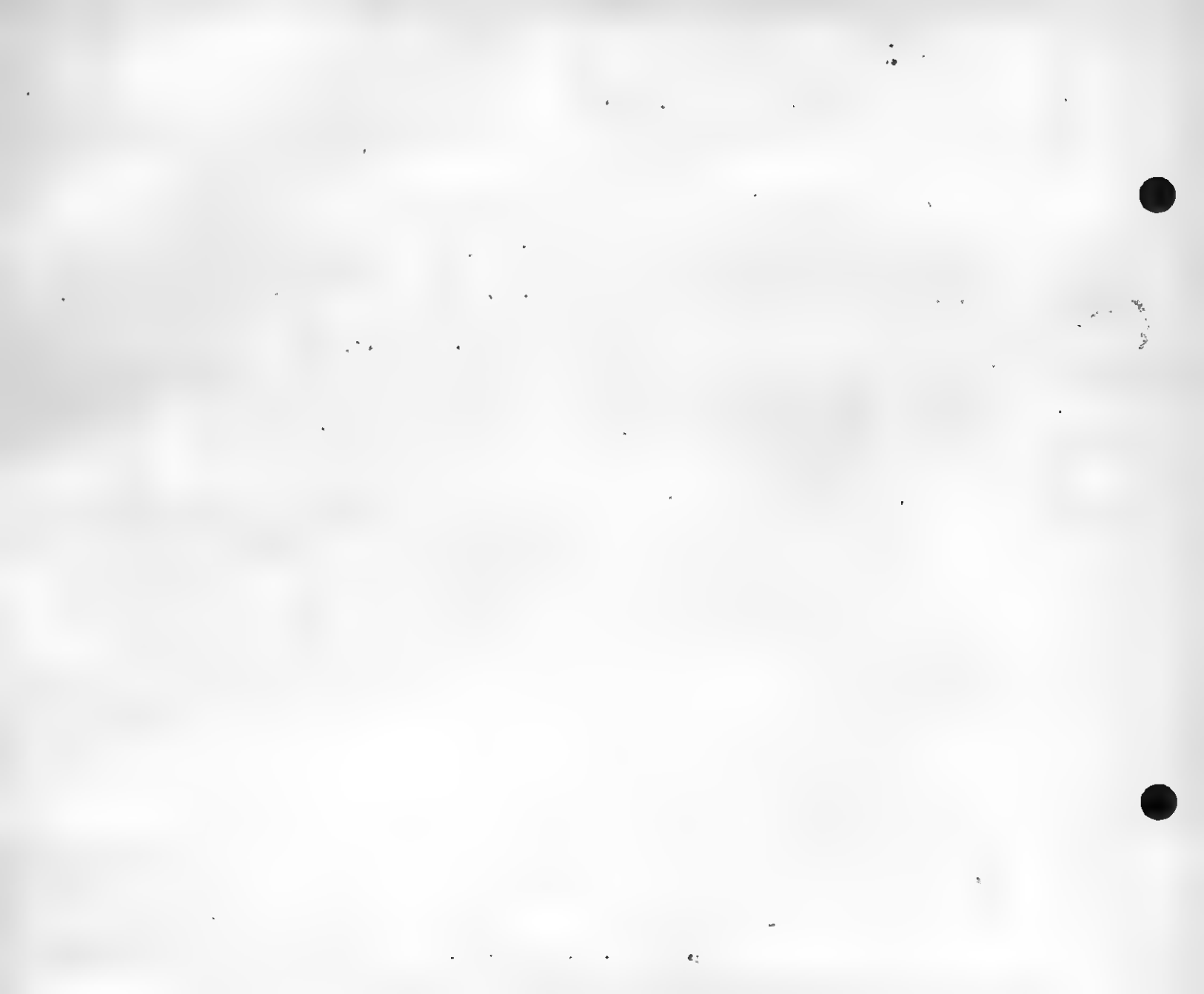
11647

CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH		2b. HOUR	
Ellen Lovell Banks					Month	Day	Year	
3 SEX		4. RACE		5 DATE OF BIRTH		6 AGE (in years last birthday)		7. IF UNDER 1 YEAR
Female		Negro		January 4, 1888		8 YRS.		IF UNDER 24 HRS.
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		
Virginia		U S A				Montgomery Md		
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
Shelton Wheaton		University Nursing Home						
13a. USUA. RESIDENCE (Where deceased lived; if admission) STATE		13b. COUNTY		13c. CITY OR TOWN		3a. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER
D.C.		13		D. C.				1507 Evarts St., N. E.
14 FATHER'S NAME		First	Middle	Last	15 MOTHER'S MAIDEN NAME		First	Middle
Willis Twyman					Lottie Lovell			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address		
no								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) metastatic carcinoma of breast								1 yr
174X DUE TO, OR AS A CONSEQUENCE OF								
Conditions, if any, which gave rise to immediate cause (a), storing the underlying cause last.								
(b) DUE TO, OR AS A CONSEQUENCE OF								
(c)								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
170X								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		State
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE				DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED
22d. PHYSICIAN'S NAME (Type)								
Myron L. Leiber								
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
		July 13, 1968		n		Elkwood, Virginia		
24. FUNERAL DIRECTOR				ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE
Frazier's Funeral Home, 309 K. D. Ave., N.W.				D. C.		DATE AUG 21 1968		Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED NAME (Type or print) First Middle Last Frank Emile Barbero					2a. DATE OF DEATH Month Day Year 7 31 68			2b. HOUR 7:30 AM	
3. SEX Male		4. RACE white		5. DATE OF BIRTH 6/15/95		6. AGE (in years last birthday) 73 YRS		7. UNDER 1 YEAR MONTHS DAYS	
7a. BIRTHPLACE (State or foreign country) ITALY		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.			
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Holy Cross Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired) Bakery			12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 8208 New Hampshire Ave	
14. FATHER'S NAME First Middle Last Pietro Barbero			15. MOTHER'S MARYEN NAME First Middle Last Natalina Archiera			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)			
16b. SOCIAL SECURITY NO 578-09-0895			17. INFORMANT Vada O. Barbero, 8208 New Hampshire Ave						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Heart Disease - Indeterminate etiology</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>15 yrs.</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Peptic Ulcer, Holecystitis - Post operative hernia repair</u>									
19a. DATE OF OPERATION 7/3/68		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Internal Hernia</u>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 68		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>Spring</u> , 1967, to <u>31 July</u> , 1968, that (I) (we) last saw the deceased alive on <u>30 July</u> , 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Ira N. Tublin</u>		22c. DATE SIGNED 7/31/68		22d. PHYSICIAN'S NAME (Type) Ira N. Tublin, MD.		22e. ADDRESS 800 Pershing Drive, Silver Spring, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE August 3, 1968		23c. NAME OF CEMETERY OR CREMATORY Cedar Creek Christian Church Cemetery		23d. LOCATION (City or Town) (County) (State) Zapp Sherrillsburg Virginia			
24. FUNERAL DIRECTOR Clark E. Wisor, Clark E. Wisor & Son, Inc. Warner E. Punthrey, Inc.		24b. ADDRESS 8434 Georgia Ave. Silver Spring, Md.		25a. REC'D BY REGISTRAR DATE AUG 6 1968		25b. REGISTRAR'S SIGNATURE J. Charles Judge			



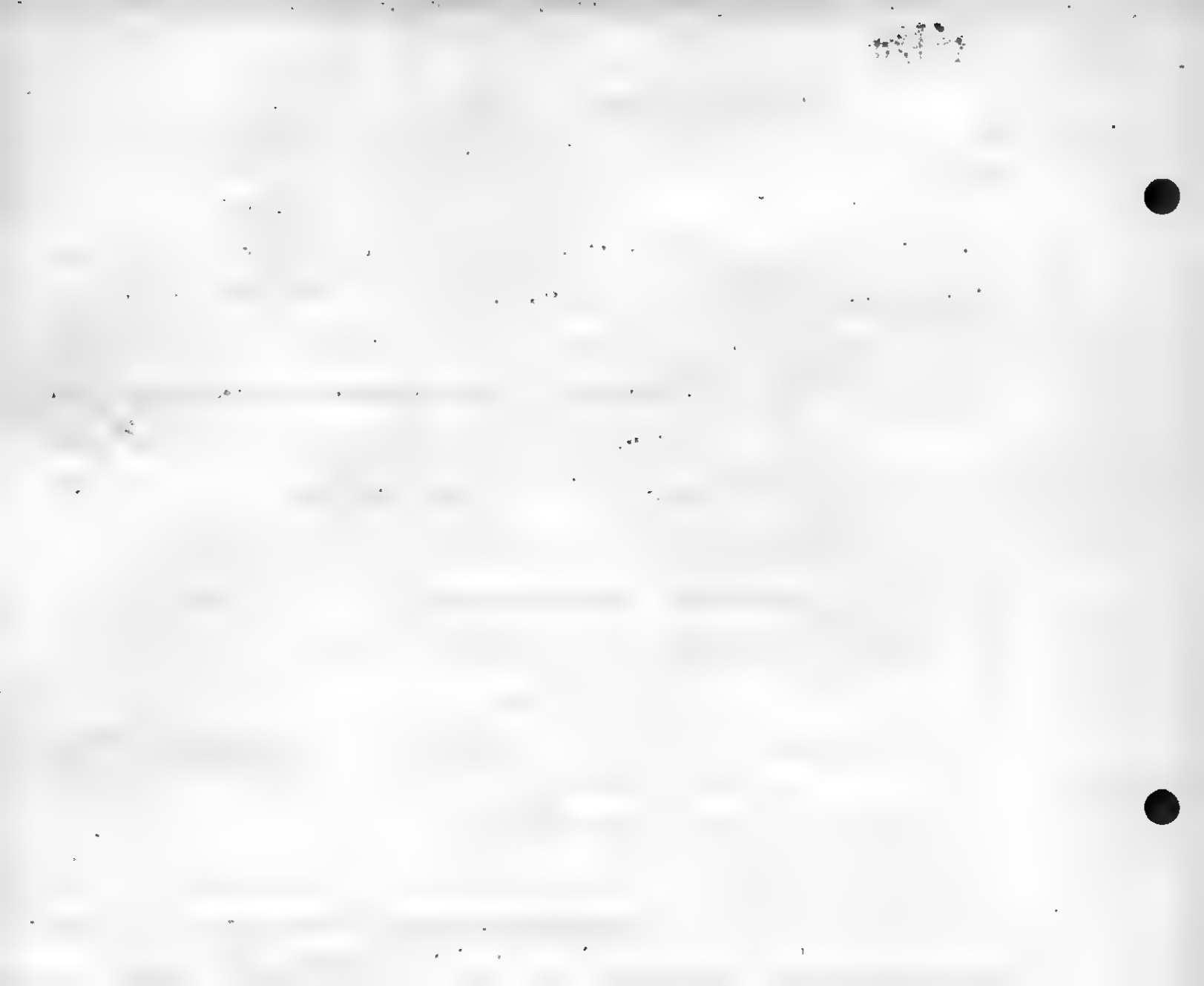
10120

CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR 11 A 20 M	
Katherine		Alberta	Barnes	July 8 1968				
3. SEX F	4. RACE W		5. DATE OF BIRTH Feb. 1, 1882		6. AGE (In years last birthday) 86 YRS		IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN
7a. BIRTHPLACE (State or foreign country) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.		
10. CITY OR TOWN OF DEATH Gaithersburg		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Asbury Methodist Home		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Office work		12b. KIND OF BUSINESS OR INDUSTRY Government		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Washington, D.C.		13b. COUNTY Wash. D. C.		13c. CITY OR TOWN Wash. D. C.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 4825-16th St., N.W.
14. FATHER'S NAME First Middle Last Fred W. Lewis		15. MOTHER'S MAIDEN NAME First Middle Last Katherine E. MOONEY Money						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown No		16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 577-50-8683-A		17. INFORMANT Address Asbury Methodist Home, Gaithersburg, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> 457 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cerebral Arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>5 yrs.</u> Approximate interval between onset and death 5 yrs.								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 312X								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <u>2/23/65</u> , 19____, to <u>7/8/68</u> , 19____, that (I) (we) last saw the deceased alive on <u>7/7/68</u> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <u>Henry C. Scruggs, M.D.</u>				22c. DATE SIGNED <u>7/8/68</u>		22d. ADDRESS 5413 Cedar Lane, Bethesda, Maryland		
23a. BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE 7-11-1968		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		23d. LOCATION (City or Town) (County) (State) Bladensburg, Prince Georges, Md.		
24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc., 5130 Wiso. Ave. N.W., Wash., D.C., 20016				25a. REC'D BY REGISTRAR JUL 10 1968		25b. REGISTRAR'S SIGNATURE Charles Judge		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED NAME (Type or print) Walter Scott Barnes						2a. DATE OF DEATH Month July Day 11 Year 1968			2b. HOUR 4:15 A.M.		
3 SEX Male		4 RACE White		5 DATE OF BIRTH September 25, 1985		6 AGE (In years last birthday) 82 YRS.		7 UNDER YEAR MONTHS		8 UNDER 24 HRS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? America		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Montgomery Md.					
10 CITY OR TOWN OF DEATH Takoma Park		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington Sanitarium				12a. USUA. OCCUPATION (Kind of work done during most of working life, even if retired) Retired Truck Driver			12b. KIND OF BUSINESS OR INDUSTRY Agriculture Center		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 432 Northwest Drive			
14. FATHER'S NAME First William Henry Middle Barnes Last Barnes				15. MOTHER'S MAIDEN NAME First Mary Middle Ann Last Stillwell							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no		16b. SOCIAL SECURITY NO. 217-52-8796		17 INFORMANT Bessie Watson		Address 632 S. Taylor St. Arlington, Va.					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))											
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Vascular Accident											
DUE TO, OR AS A CONSEQUENCE OF (b) Hypertension											
DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerosis											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Pyelonephritis, Senility											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from June 10, 1968 , to July 11, 1968 , that (I) (we) last saw the deceased alive on July 10, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Philip E. Jones M.D.				DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 7/11/68			
22d. PHYSICIAN'S NAME (Type) Philip E. Jones MD				22e. ADDRESS 800 Pershing Drive Silver Spring, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE July 13, 1968		23c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery		23d. LOCATION (City or Town) Washington, D.C.		(County)		(State)	
24 FUNERAL DIRECTOR W. Lee Jones				ADDRESS 8434 Georgia Ave.		25a. REC'D BY REGISTRAR Charles Judge		25b. REGISTRAR'S SIGNATURE Charles Judge		DATE JUL 17 1968	



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Item 3 should be used as a burial-transit permit. Five pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

10122

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or Print) First Middle Last CLARENCE ALBERT BATEMAN			2a. DATE KNOWN OF EST. DEATH <input checked="" type="checkbox"/> Month Day Year 7-25-68 19		2b. HOUR 10:35 P M
3. SEX M	4. RACE CAUS.	5. DATE OF BIRTH 10-15-80	6. AGE (In years past birthday) 87 YRS	7. IF UNDER 1 YEAR MONTHS DAYS	7c. DATE PRONOUNCED DEAD Month 7- Day 25 Year 19 68
7a. BIRTHPLACE (State or foreign country) WASH. D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH MONTGOMERY	
10. CITY OR TOWN OF DEATH TAKOMA PARK		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital) WASHINGTON SANITARIUM		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Retired Pat-Atty	12b. KIND OF BUSINESS OR INDUSTRY Law
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE MD.		13b. COUNTY Montgomery	13c. CITY OR TOWN SILVER SPRING	13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO	13e. STREET AND NUMBER 106 Franklin Ave.
14. FATHER'S NAME First Middle Last WILLIAM P. BATEMAN			15. MOTHER'S MAIDEN NAME First Middle Last MARLENET		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16b. SOCIAL SECURITY NO 215-38-4949		17. INFORMANT Dr. John Bateman ADDRESS L. I. New York PREVIOUS HOSPITAL CHART Port Jefferson	
18. CAUSE OF DEATH (Enter only one cause per line or (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Insufficiency DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 720					
19a. DATE OF OPERATION 7-20		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No City or Town County State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Belden R. Keap M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS 22b. DATE SIGNED July 26, 1968			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE July 29, 1968	23c. NAME OF CEMETERY OR CREMATORY Congressional Cemetery		23d. LOCATION City or Town (County) (State) Washington, DC	
24. FUNERAL HOME C. Glen Carter Warner E. Pumphrey, Inc. 8434 Ga. Ave. Sil Spg.		25a. REC'D BY REGISTRAR JUL 31 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1 DECEASED-NAME (Type or print) First Middle Last <i>Lawrence W. Bates</i>			2a DATE OF DEATH Month Day Year <i>July 22 1968</i>			2b HOUR <i>9 A</i>			M	
3 SEX <i>Male</i>		4 RACE <i>Negro</i>		5 DATE OF BIRTH <i>3/29/18</i>		6 AGE (in years last birthday) <i>50</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a BIRTHPLACE (State or foreign country) <i>So. Carolina</i>		7b CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <i>Montgomery</i> Md.				
10 CITY OR TOWN OF DEATH <i>Bethesda</i>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Sibley Hospital</i>		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Retired</i>		12b KIND OF BUSINESS OR INDUSTRY <i>N.I.H.</i>				
13a USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE <i>DC</i>			13b COUNTY <i>Washington</i>		13c CITY OR TOWN <i>Washington</i>		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER <i>7 Girard St.</i>	
14 FATHER'S NAME First Middle Last <i>Wheeler Bates</i>			15 MOTHER'S MAIDEN NAME First Middle Last <i>Jessie Dunbar</i>							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) <i>No</i>			16b SOCIAL SECURITY NO. <i>None</i>		17 INFORMANT <i>Brother Lawrence Bates</i>		Address <i>Wash D.C. 5705 1st St NW</i>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocarditis</i> <i>425X</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>5 years</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <i>1122</i>										
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>yes</i>			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)						
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <i>April, 1965</i> , to <i>July, 1968</i> , that (I) (we) last saw the deceased alive on <i>July 21, 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death										
22b. SIGNATURE <i>Marvin Wadler, M.D.</i> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					22c. DATE SIGNED <i>July 22, 1968</i>					
22d. PHYSICIAN'S NAME (Type) <i>MARVIN WADLER, M.D.</i>					22e. ADDRESS <i>8218 Wisconsin Av. Bethesda, Md.</i>					
23a BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <i>7-28-68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>SUMNER MEMORIAL PARK</i>		23d. LOCATION (City or Town) (County) (State) <i>SUMNER, S.C.</i>				
24 FUNERAL DIRECTOR <i>JOHN T. RHINES Co.</i>					ADDRESS <i>3015 12TH STREET, N. E.</i>		25a REC'D BY REGISTRAR <i>JUL 26 1968</i>		25b REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>	
					WASHINGTON, D. C.					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

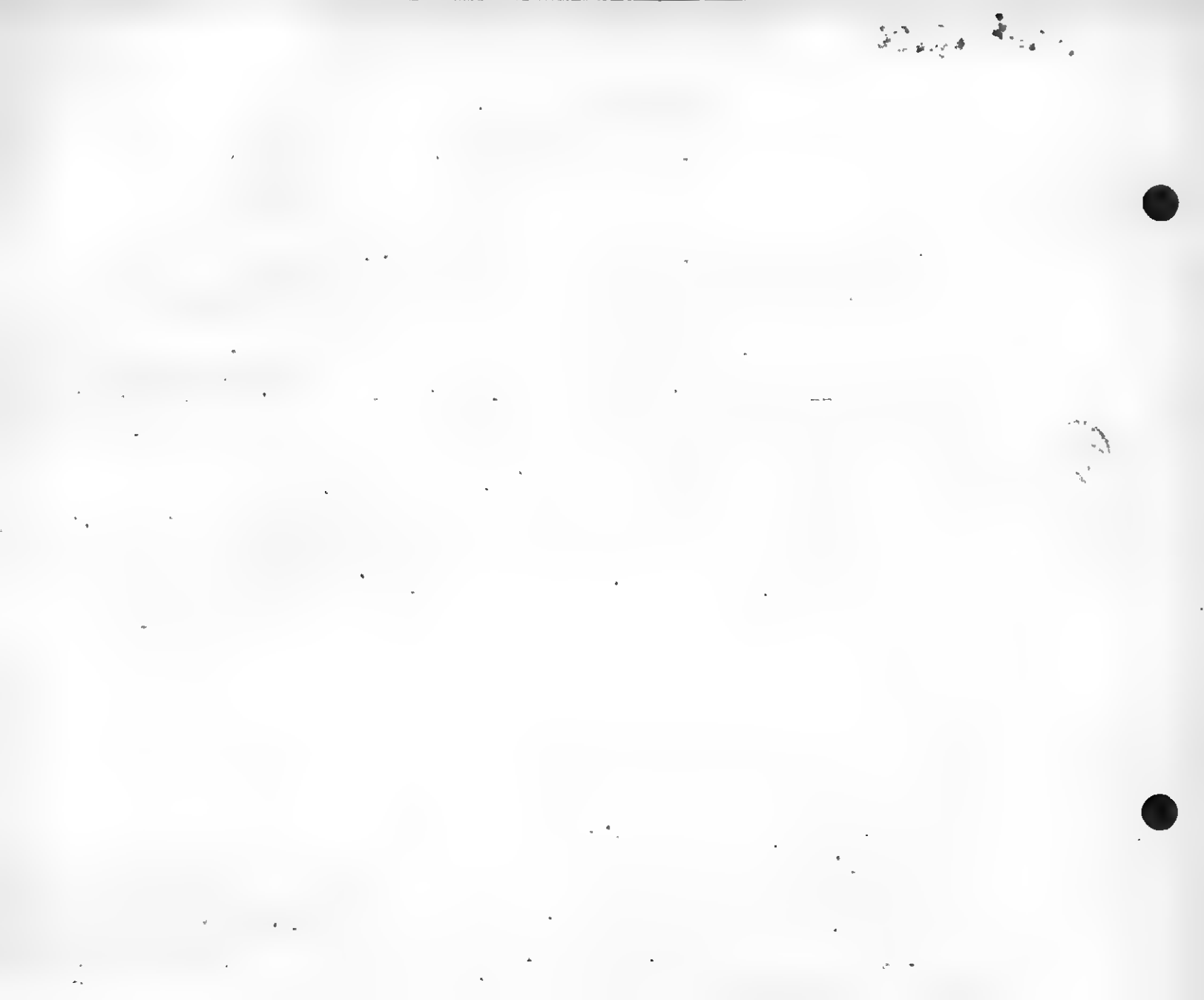
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1-3 10124

10135

1 DECEASED-NAME (Type or print) Grace Evelyn Beasley			2a. DATE OF DEATH Month July Day 10 Year 1968			2b. HOUR 9:10 A.M.			
3 SEX Female		4. RACE Cauc.		5 DATE OF BIRTH May 5, 1885		6 AGE (In years last birthday) 83 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Ohio		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.			
10. CITY OR TOWN OF DEATH Jakoma Park		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Wash. Sanitarium & Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Cwn Home			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. WIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 11 Hittop Road	
14 FATHER'S NAME First Middle Last John W. McGowan			15 MOTHER'S MAIDEN NAME First Middle Last Elizabeth J. Beloit						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no		16b. SOCIAL SECURITY NO 220-44-6488		17. INFORMANT Mrs. Eileen P. Dare Address 1408 Bernard Place Rockville, Maryland					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 431.0 DUE TO, OR AS A CONSEQUENCE OF (b) Arterial Hypertension 104.0 DUE TO, OR AS A CONSEQUENCE OF (c) Generalized Arteriosclerosis 331.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 days 10 years Undetermined	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Carcinoma of urinary bladder									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from Sept 5, 1958 to July 10, 1968 , that (I) (we) lost saw the deceased alive on July 9, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE George L. Ball DEGREE				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED July 11, 1968			
22d. PHYSICIAN'S NAME (Type) George L. Ball				22e. ADDRESS 10630 Georgia Ave Silver Spring, Md					
23a. BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE July 13, 1968		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Suitland, Maryland			
24. FUNERAL DIRECTOR Warner E. Pumphrey, Inc. 8434 Georgia Ave. Silver Spring, Md.				25a. REC'D BY REGISTRAR JUL 17 1968		25b. REGISTRAR'S SIGNATURE William Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR 151
30M REV 1-68

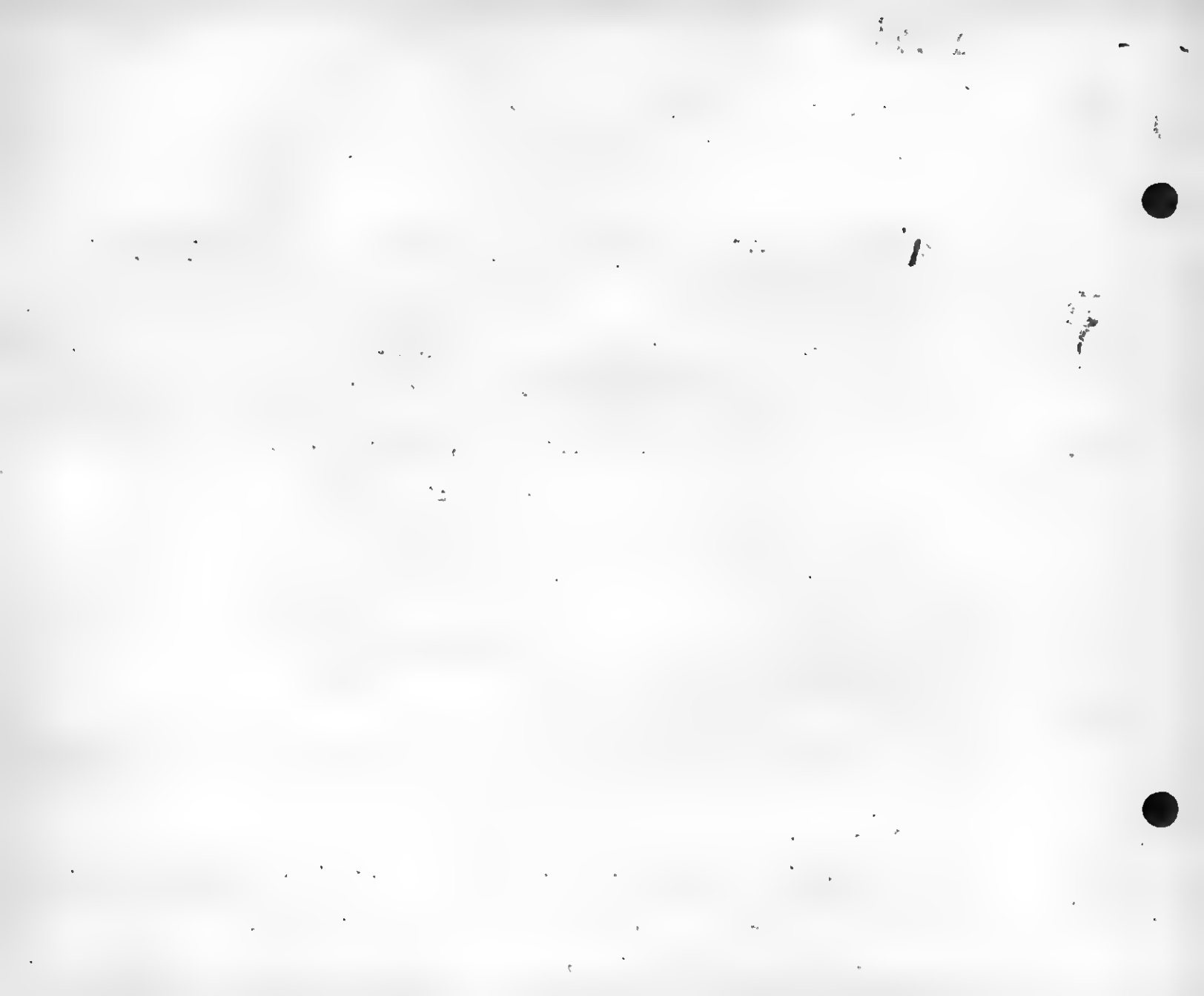
10128

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

10136

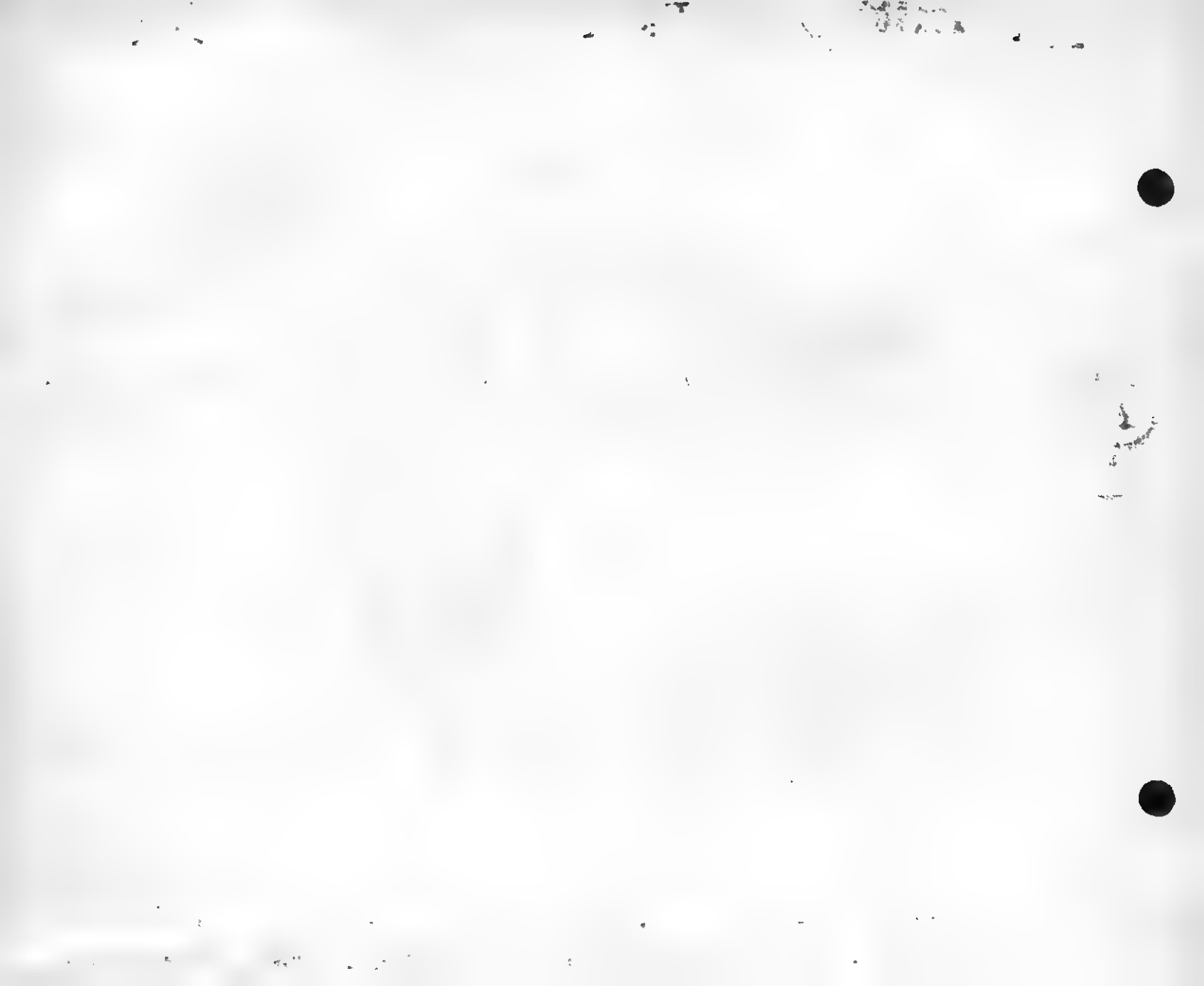
1. DECEASED-NAME (Type or print) <i>George</i> First Middle Last			2a. DATE OF DEATH Month <i>July</i> Day <i>25</i> Year <i>1968</i>			2b. HOUR <i>7:40</i> AM	
3. SEX <i>male</i>		4. RACE <i>W</i>		5. DATE OF BIRTH <i>2/17/09</i>		6. AGE (in years last birthday) <i>59</i> YRS	
7a. BIRTHPLACE (State or foreign country) <i>Ohio</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i> Md.	
10. CITY OR TOWN OF DEATH <i>Bethesda</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Industrial Engineer</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>US Post Office</i>	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <i>Md</i>		13b. COUNTY <i>Mont</i>		13c. CITY OR TOWN <i>Guthrie</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER <i>15810 Norman Dr.</i>		14. FATHER'S NAME First Middle Last <i>Martin Beck</i>		15. MOTHER'S MAIDEN NAME First Middle Last <i>Katherine Wilsch</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, No, or unknown <i>No</i>		16b. SOCIAL SECURITY NO. <i>289-10-8139</i>		17. INFORMANT <i>Wife Alberta Beck</i>		Address <i>Same as above</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a) (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial infarction, recent & remote</i> <i>410.1</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: <i>420.1</i> (b) <i>coronary arteriosclerosis, severe</i> DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <i>Diverticulitis, ruptured with abscess formation</i>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <i>7-19-1968</i> to <i>7-25-1968</i> , that (I) (we) last saw the deceased alive on <i>7-24-1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Linwood H. Johnson</i>				22c. DATE SIGNED <i>7-25-68</i>			
22d. PHYSICIAN'S NAME (Type) <i>LINWOOD H. JOHNSON JR.</i>				22e. ADDRESS <i>4405 E-W Highway Bethesda, Md.</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>7-29-68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Darnestown Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Darnestown, Maryland</i>	
24. FUNERAL DIRECTOR <i>ROBERT A. PUMPHREY, Bethesda, Maryland</i>				25a. REC'D BY REGISTRAR <i>AUG 2 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The funeral director should remove carbon papers. Page 1 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div>10126</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>Item 7a, b, Film GL 03 8/6/68 km</div> <div>CERTIFICATE OF DEATH</div>										
1. DECEASED-NAME (Type or print) First Middle Last Edward Beetham					2a. DATE OF DEATH Month Day Year July 25 1968			7b. HOUR 1:40 PM		
3. SEX MALE		4. RACE CAUCASIAN		5. DATE OF BIRTH		6. AGE (In years last birthday) 88 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) England		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.				
10. CITY OR TOWN OF DEATH ROCKVILLE			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, street address) POTOMAC VALLEY NURSING HOME			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD.			13b. COUNTY MONTGOMERY			13c. CITY OR TOWN POOLESVILLE		13e. STREET AND NUMBER RED #1 Box 95		
14. FATHER'S NAME First Middle Last Joseph Beetham					15. MOTHER'S M.A.DEN NAME First Middle Last Mary Robinson					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) No			16b. SOCIAL SECURITY NO 578-01-9345		17. INFORMANT Miss Edith Beetham Address Same as Item 13.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cirrhosis of the Liver DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 5876 (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Months										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Akute myocardial infarction - Senility										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from 9 Oct 1961 , to 25 July 1968 , that (we) last saw the deceased alive on 22 July 1968 , and that in (our) opinion death occurred on the date and hour and from the causes stated above, (we) (do) (did not) view the body after death										
22b. SIGNATURE Gordon Murdoch Smith, MD			DEGREE MD			ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 25 July 68		
22d. PHYSICIAN'S NAME (Type) Gordon Murdoch Smith, MD			22e. ADDRESS Boyd's, Md 20720							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 7-27-68		23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Church Cem.			23d. LOCATION (City or Town) (County) (State) Arlington, Virginia		
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Maryland					25a. REC'D BY REGISTRAR DATE AUG 2 1968		25b. REGISTRAR'S SIGNATURE J. Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV 1/68

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year			2b. HOUR		
Dorsey L. Bennett						July 7, 1968			11:55		
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (In years lost birth day)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
Male		White		Nov. 29, 1879		88 YRS					
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Maryland		USA				Montgomery Md.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Boyd		Boyd-Clarksburg Rd.				Farmer					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER			
Maryland		Montgomery		Boyd				Boyd-Clarksburg Rd.			
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME								
First Middle Last			First Middle Last								
Samuel Bennett			Ann Summers								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO		17. INFORMANT Address						
No					Leroy Bennett, Boyd, Md.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease										20 years	
DUE TO, OR AS A CONSEQUENCE OF Generalized Arteriosclerotic Cardiovascular Disease with Hypertension.										20 years	
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.											
(b) DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
None						YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
<input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		HOUR A.M. Month Day Year P.M.		No accident							
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or RFD No. City or Town County State							
White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>											
22a. I certify that (I) (this hospital) attended the deceased from 1942, 19 to July 7, 1968, that (I) (we) saw the deceased alive on July 7, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE						22c. DATE SIGNED					
M. McKendree Boyer, M.D.						July 8, 1968					
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS					
M. McKendree Boyer, M.D.						9701 Church Street Damascus, Maryland.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
Burial		July 9, 1968		Clarksburg Meth.		Clarksburg, Md.					
24. FUNERAL DIRECTOR ADDRESS						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Olin L. Molesworth, Damascus, Md.						JUL 11 1968		Charles Judge			

MEDICAL CERTIFICATION



DA

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers (pages 1 and 2) and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1 DECEASED-NAME (Type or print) GUY				First Walter Middle BETTY Last		2a. DATE OF DEATH Month July Day 9 Year 1968		2b. HOUR 6:30	
3 SEX Male		4 RACE white		5. DATE OF BIRTH 3/15/1915		6. AGE (In years lost birthday) 53 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) New York		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Montgomery Md			
10. CITY OR TOWN OF DEATH Silver Spring		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Holy Cross Hospital		12a. USUA. OCCUPAT ON (Kind of work done during most of work ng life, even if retired) Machinist - Johns Hopkins Lab.		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Wheaton		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 2404 Mason St.	
14 FATHER'S NAME First Walter Middle G. Last Betty				15. MOTHER'S MAIDEN NAME First Mary Middle Treeburn Last					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or Unknown yes		16b. SOCIAL SECURITY NO. 290-10-7946		17. INFORMANT Jane F. Betty Wheaton, Maryland					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Malignant melanoma, metastatic, to 1729 DUE TO, OR AS A CONSEQUENCE OF (b) lymph nodes and internal organs. DUE TO, OR AS A CONSEQUENCE OF (c) Bilateral bronchopneumonia. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from May , 19 53 to July 9, 1968 , that (I) (we) last saw the deceased alive on July 8, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Eldon R. Keap				DEGREE PHYS		ATTENDING <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED July 9, 1968	
22d. PHYSICIAN'S NAME (Print) ELDON R. KEAP M.D.				22e. ADDRESS Wheaton, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE July 12, 1968		23c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery		23d. LOCATION (City or Town) (County) (State) Rockville, Maryland			
24. FUNERAL DIRECTOR'S NAME Warner E. Pumphrey, Inc.		24b. ADDRESS 8434 Annapolis Avenue Silver Spring, Maryland		25a. REC'D BY REGISTRAR JUL 15 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			

8A



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

20130

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED NAME (Type or Print) First Middle Last Fannie Beverly			2a DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> Month Day Year 7-18 68			2b HOUR 7:45 M
3 SEX Fe	4 RACE Cauc	5 DATE OF BIRTH APR. 1 1898	6 AGE in YRS MONTHS DAYS 70	7 UNDER 24 HRS IF UNDER 24 HRS HOURS MIN	2c DATE PRONOUNCED DEAD 7-18 68	
7a BIRTHPLACE (State or foreign country) Virginia		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Montgomery Md
10 CITY OR TOWN OF DEATH Kensington		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Kensington Gardens Asy Home		12a USUAL OCCUPATION (Kind of work doing most of working life, even if retired) Housewife		12b KIND OF BUSINESS OR INDUSTRY none
13a USUAL RESIDENCE (Where deceased lived, or last residence before admission) STATE VA		13b CITY OR TOWN ALEXANDRIA		13c STREET AND NUMBER 1002 King Street		
14 FATHER'S NAME First Middle Last Jacob A. Edwards			15 MOTHER'S MAIDEN NAME First Middle Last Jennie Fewell			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16b SOCIAL SECURITY NO		17 INFORMANT ADDRESS Mrs. Lottie Edwards 2811 School St. Alex., Va.		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Squamous cell Carcinoma DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) of mouth with Pulmonary DUE TO, OR AS A CONSEQUENCE OF (c) Metastases APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 144						
19a DATE OF OPERATION 144		19b CONDITION FOR WHICH OPERATION WAS PERFORMED?		20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18.)		
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No City or Town County State		
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>						
ACTUAL SIGNATURE EXAMINER'S NAME (Type) BELDEN R. REAP		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b DATE SIGNED July 18, 1968		
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE 20 July 68		23c NAME OF CEMETERY OR CREMATORY National Memorial Park		
24 FUNERAL DIRECTOR B. Earle Mountcastle		23d LOCATION (City or Town) (County) (State) Falls Church, Fairfax, Virginia		25a REC'D BY REG STRAR JUL 22 1968		
Cunningham Funeral Home, Alexandria, Virginia		25b REG STRAR'S SIGNATURE J. Charles Judge				



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Pages 1, 2, and 3. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (3)
10M REV 1/68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1 DECEASED NAME (Type or Print) BERTIE ARVELLA BIBLE						2a DATE KNOWN OF ESTI-DEATH MATED <input checked="" type="checkbox"/> 7 5 1968			2b HOUR 6:15 PM		
3 SEX F	4 RACE W	5 DATE OF BIRTH 11-24-15	6 AGE (In years last birthday) 52 YRS.	IF UNDER 1 YEAR MONTHS 0 DAYS 0	IF UNDER 24 HRS. HOURS 0 MIN 0	2c DATE PRONOUNCED DEAD Month 7 Day 5 Year 1968			2d HOUR 6:15 PM		
7a. BIRTHPLACE (State or foreign country) TENN		7b. CIT. ZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH MONTGOMERY			Md.		
10 CITY OR TOWN OF DEATH TAKOMA PARK			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) WASH. SAN 3 HOSP			12a. USJA. OCCUPAT ON (Kind of work done during most of working life, even if retired.) H. Wife			12b. KIND OF BUSINESS OR INDUSTRY Home		
13a. USJA. RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MD			13b. COUNTY Mont.			13c. CITY OR TOWN SILVER SPRING			3d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME First ABIJAH Middle SEAL Last SEAL			15. MOTHER'S MAIDEN NAME First AMANDA Middle RHEA Last RHEA			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no			16b. SOCIAL SECURITY NO -		
17. INFORMANT PATIENT			ADDRESS								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Thrombosis Acute										4 yrs.	
DUE TO, OR AS A CONSEQUENCE OF (b) Cardiovascular Disease										years.	
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
42											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day Year 19 HOUR A.M. 19 P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No		City or Town		County		State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE John G. Ball		EXAMINER'S NAME (Type) John G. Ball		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASS STANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED July 5, 1968	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 7/8/68		23c. NAME OF CEMETERY OR CREMATORY Seal Farm		23d. LOCATION (City or Town) Etchison Mont. Md.		(County)		(State)	
24. FUNERAL DIRECTOR Francis H. Barber ADDRESS Laytonsville, Md.						25a. REC'D BY REGISTRAR JUL - 9 1968		25b. REGISTRAR'S SIGNATURE J. Charles Judge			

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and at any event, within 72 hours after death.

VR A15 (4)
30M REV 11/68

MARTLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
10138 CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR		
Margaret Tenley BLOCK						July 21 68			1050P M		
3 SEX		4 RACE		5. DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS			
Female		Caucasian		Feb. 13, 1925		43 YRS.					
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH					
Washington, D.C.		USA				Montgomery Md.					
10. CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b KIND OF BUSINESS OR INDUSTRY			
Bethesda			Naval Hospital			N/A					
13a USUAL RESIDENCE (Where deceased lived, if institution admission) STATE			13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER		
Maryland			Pr. George		Bowie				3861 Irongate Lane		
14 FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last
John Edward Brennan						Lilly May Tenley					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SECURITY NO.			17 INFORMANT			Address		
No			578267371			Mr. Chester J. Block			3861 Irongate Lane Md.		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinoma of the breast with metastases to</u>											
174X DUE TO, OR AS A CONSEQUENCE OF <u>brain</u>											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____											
(c) _____											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
170X											
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)							
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e PLACE OF INJURY (AT HOME FARM STREET, FACTORY, OFFICE BUILDING ETC)		21f LOCATION Street or RFD No		City or Town		County		State	
22a. I certify that (X) (this hospital) attended the deceased from <u>June 13, 1968</u> , to <u>July 21, 1968</u> , that (X) (we) last saw the deceased alive on <u>July 21, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death.											
22b SIGNATURE		22c DATE SIGNED				ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		July 22, 1968			
22d. PHYSICIAN'S NAME (Type)		22e ADDRESS									
J. R. FLETCHER, M. D.		Naval Hospital, Bethesda, Md.									
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town)		(County)		(State)	
Burial		7/25/1968		Ft. Lincoln Cemetery		Bladensburg, Md.					
24 FUNERAL DIRECTOR						25a. REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE			
Malley's Funeral Home						JUL 25 1968		Charles Judge			
3200 Rhode Island Avenue, Mt. Ranier, Md.						DATE					

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal and in any event within 72 hours after death.

10133

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1144

1. DECEASED-NAME (Type or Print) CHARLES ALLEN BOEHMER		First BOEHMER Middle BOEHMER Last		2a. DATE KNOWN OF ESTI-DEATH MATED <input checked="" type="checkbox"/> 7-31-68 19		2b. HOUR 7:30 PM	
3 SEX Male	4 RACE White	5 DATE OF BIRTH 3-6-42	6 AGE (in years last birthday) 19 YRS	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN	2c. DATE PRONOUNCED DEAD Month 8-1-68 Year 19	
7a. BIRTHPLACE (State or foreign country) Wisconsin		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.	
10. CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Washington, San. & Hosp.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) U.S. Marines		12b. KIND OF BUSINESS OR INDUSTRY	
13a. U.S.A. RESIDENCE (Where deceased lived, if institution residence before admission) STATE Id.		13b. COUNTY P.O.		13c. CITY OR TOWN Laurel		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 2800 Graefloch Rd.		14. FATHER'S NAME First Henry G. Boehmer Middle Evalyn Last		15. MOTHER'S MAIDEN NAME First Evalyn Middle Laurel Last		16. SOCIAL SECURITY NO	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16b. SOCIAL SECURITY NO Presently		17. INFORMANT Father		ADDRESS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Asphyxiation due to 110.0 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Drowning in Rocky Horse DUE TO, OR AS A CONSEQUENCE OF (c) Reservoir						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 229							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year 7-31-68		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 (Item 18)) Deceased jumped into Reservoir and drowned			
21d. INJURY OCCURRED WHERE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home farm street, factory, office building, etc.) Reservoir		21f. LOCATION Street or R.F.D. No Rte. 29 at Montgom. Cty. line City or Town MD County Montgomery State MD			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquest <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Bolden R. Reap		EXAMINER'S NAME (Type) Bolden R. Reap, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEP. TY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED 8-1-68	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 8-5-68		23c. NAME OF CEMETERY OR CREMATORY Baltimore Natl		23d. LOCATION (City or Town) Baltimore (County) MD (State)	
24. FUNERAL DIRECTOR Wahlehan Funeral Home Laurel		ADDRESS		25a. REC'D BY REGISTRAR AUG 7 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1 DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year			2b. HOUR P
Raymond			Caswell			Booth			July 8 1968 11:55
3. SEX	4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
Male	White		May 2, 1913			55 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Virginia		America				Montgomery Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
Takoma Park			Washington Sanitarium			Salesman-Giant shoe			
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
Maryland			Prince George			Hyattsville		5721 Chillum Heights	
14. FATHER'S NAME First Middle Last			15. MOTHER'S M.A.DEN NAME First Middle Last						
John Booth			Mary Scriggs						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.			17. INFORMANT Address			
no						Patient's chart			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> 157.9 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral pneumonia of pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u> <u>4 months</u>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION									
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED									
20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>									
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)									
21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19									
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work									
21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)									
21f. LOCATION Street or R.F.D. No. City or Town County State									
22a. I certify that (I) (this hospital) attended the deceased from <u>June 15, 1968</u> to <u>July 8, 1968</u> , that (I) (we) last saw the deceased alive on <u>July 8, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.									
22b. SIGNATURE <u>Lytle Williams M.D.</u> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22c. DATE SIGNED <u>July 9, 1968</u>									
22d. PHYSICIAN'S NAME (Type) <u>Lytle Williams</u> 22e. ADDRESS <u>831 University Blvd E. Silver Spring</u>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE <u>July 11, 1968</u> 23c. NAME OF CEMETERY OR CREMATORY <u>St. Luke's</u> 23d. LOCATION (City or Town) (County) (State) <u>Washington D.C.</u>									
24. FUNERAL DIRECTOR <u>William H. Williams</u> 25a. REC'D BY REGISTRAR <u>Charles Judge</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>									



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1 DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH			2b. HOUR
George Washington Boring						Month	Day	Year	11:20 AM
3 SEX	4 RACE		5 DATE OF BIRTH			6 AGE (In years last birthday)		7 IF UNDER 1 YEAR	
MALE	CAUC		8-30-92			75 YRS		MONTHS	DAYS
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
WVA			AMERICAN			9 COUNTY OF DEATH Montgomery Md.			
10. CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY
Takoma Park			Washington Southern			Retired - Apt. Maintenance			
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Md.			Montg			Silver Spring		YES <input type="checkbox"/> NO <input type="checkbox"/>	818 Woodside Pkwy
14 FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			
Charles					Boeing	MARY JANE Murphy			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.			17. INFORMATION			
Yes, no, unknown			232-01-3337			Chad W. Boring 818 Woodside Parkway Silver Spring, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> <u>1621</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>1st of Right Lung</u> DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>19 days</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)			21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>July, 1965</u> to <u>23 July 1968</u> , that (I) (we) last saw the deceased alive on <u>22 July 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Russell B. Arnold M.D.</u>						22c. DATE SIGNED <u>July 23, 1968</u>		22d. PHYSICIAN'S NAME (Type) <u>Russell B. Arnold, Md.</u>	
						22e. ADDRESS <u>1106 Spring St., Silver Spring, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
<u>Burial</u>			<u>July 26, 1968</u>		<u>Parklawn Cemetery</u>		<u>Rockville, Maryland</u>		
24. FUNERAL DIRECTOR <u>Warner E. Humphrey, Inc.</u>						25a. RECD BY REGISTRAR <u>JUL 29 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
<u>8434 Georgia Ave. Silver Spring, Md.</u>									

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-2. Pages 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 DECEASED-NAME (Type or Print)			First Middle Last			2a DATE KNOWN OF DEATH				2b HOUR	
WAYNE Kenneth			BORTNER			Month Day Year				6:30 AM	
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (n years last birthday)	7 LATER 1 YEAR	8 IF UNDER 24 HRS	2c DATE PRONOUNCED DEAD				2d HOUR	
M	W	June 2, 1944	24 YRS	MONTHS	DAYS	Month Day Year				6:30 AM	
7a BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH		
Penn.			U.S.A						Montgomery Md		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b KIND OF BUSINESS OR INDUSTRY		
Bethesda			Suburban			Truck Driver			Sydney Bakery		
13a U.S.A. RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b COUNTY			13c CITY OR TOWN			13d INSIDE CITY LIMITS?		
Pennsylvania			HARRISBURG			HANOVER			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14 FATHER'S NAME			15. MOTHER'S MAIDEN NAME			13e STREET AND NUMBER			13f ADDRESS		
Unknown			Genevieve E. Bortner			RD#5			Hanover Pa.		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO			17. INFORMANT			ADDRESS		
No			167 34 2191			Barbara L. Bortner			RD#5 Hanover Pa.		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY.											Sudden
IMMEDIATE CAUSE (a) Multiple Injuries Severe.											
DUE TO, OR AS A CONSEQUENCE OF											
(b) Trauma - Auto Accident.											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY?			
								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				21b TIME OF INJURY Month, Day, Year				21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
				6:30 PM 7/18 1968				Lost control of truck when struck stalled car			
21d INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f LOCATION Street or RFD No City or Town County State			
				Beltway				495 at GW Parkway apt. 208 John John Mont. Md			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE				CHIEF MEDICAL EXAMINER				22b. DATE SIGNED			
John B. Ball								7/18/68			
EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER							
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
				ADDRESS (Street, city, town, or county)							
23a BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY			
Burial				7/21/1968				St. John's Cemetery			
								23d. LOCATION (City or Town) (County) (State)			
								Abbottstown Adams Co. Pa.			
24 FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR				25b. REGISTRAR'S SIGNATURE			
Fred F. Feiser				New Oxford, Pa.				J. Charles Judge			

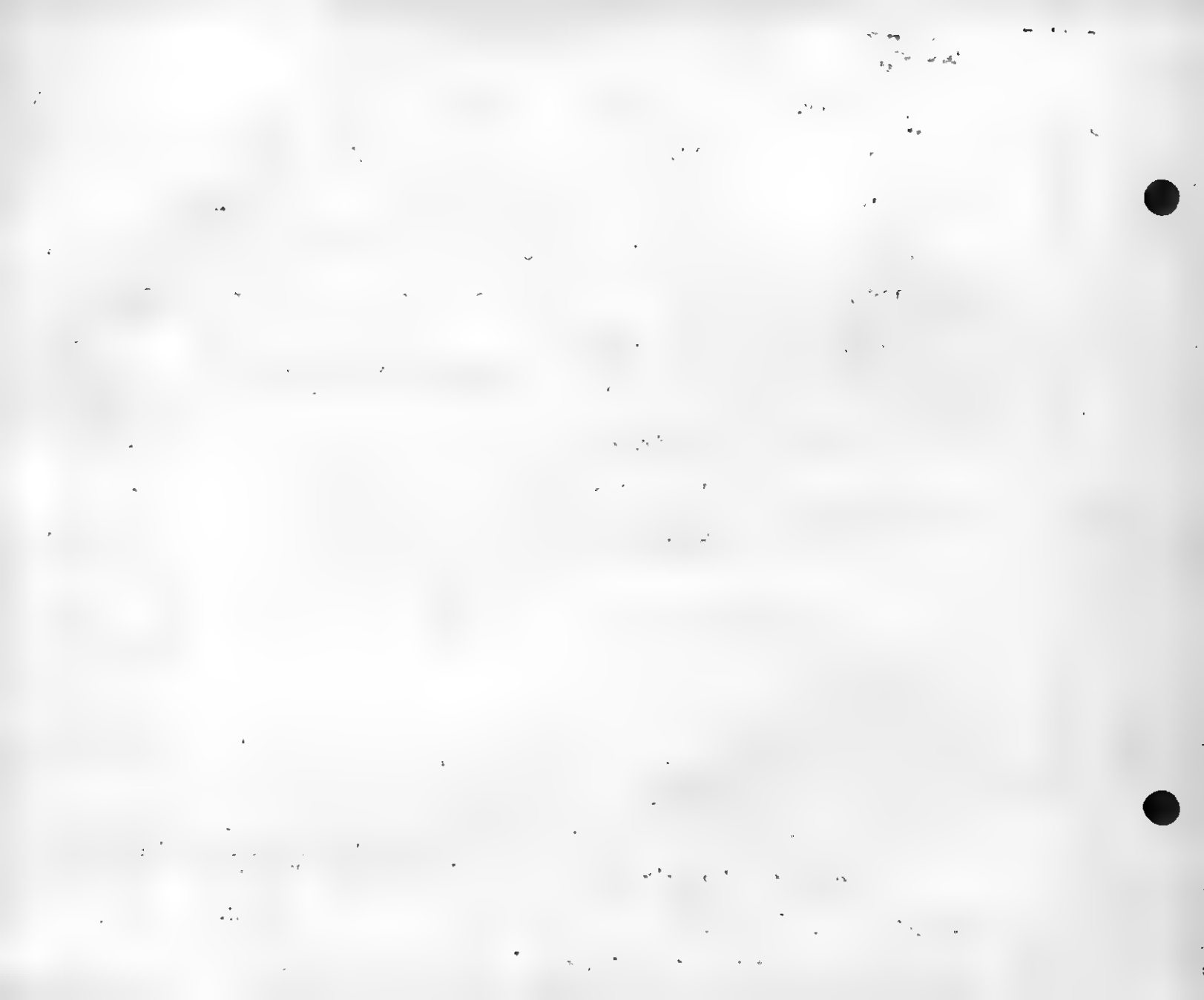


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies (pages 1 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) Anna Dina Brand			2a DATE OF DEATH Month July Day 29 Year 1968			2b HOUR P 2:30 M			
3 SEX Female		4. RACE White		5 DATE OF BIRTH 22 August 1957		6 AGE (In years last birthday) 10 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) California		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.			
10 CITY OR TOWN OF DEATH Bethesda		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) The Clinical Center, NIH		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Student		12b KIND OF BUSINESS OR INDUSTRY None			
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE California		13b. COUNTY Roseville		13c CITY OR TOWN Roseville		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 302 Brentwood Road	
14. FATHER'S NAME First Middle Last Joaquin Brand			15. MOTHER'S MAIDEN NAME First Middle Last Anna Soto Dina Brand						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No		16b SOCIAL SECURITY NO. None		17 INFORMANT The Medical Record Address The Clinical Center, NIH, Bethesda, Maryland					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Respiratory Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Generalized Sepsis DUE TO, OR AS A CONSEQUENCE OF (c) Lymphosarcoma								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes 2 weeks 2 1/2 years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (At home farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that Dr (this hospital) attended the deceased from 9 June , 19 68 , to 29 July , 19 68 , that Dr (we) last saw the deceased alive on 29 July , 19 68 , and that in our (our) opinion death occurred on the date and hour and from the causes stated above, Dr (we) (did) (did not) view the body after death.									
22b SIGNATURE David A. Bray		DEGREE M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c DATE SIGNED 30 July 1968			
22d. PHYSICIAN'S NAME (Type) David A. Bray, M.D.		22e ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Maryland							
23a BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b DATE 8-2-1968		23c NAME OF CEMETERY OR CREMATORY W.W. Chambers Co 1400 Chapin St NW		23d LOCATION (City or Town) (County) (State) ROSEVILLE, CALIF.			
24 FUNERAL DIRECTOR W.W. Chambers Co		ADDRESS 1400 Chapin St NW		25a REC'D BY REGISTRAR JUL 31 1968		25b REGISTRAR'S SIGNATURE J Charles Judge			



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VR A15 (4)
30M REV 1/68

MONTGOMERY COUNTY, MARYLAND DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH									
1 DECEASED NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH			2b. HOUR
JULIUS			G		Breakstone	7 Month 22 Day 68 Year			9:00 AM
3. SEX		4 RACE		5 DATE OF BIRTH		6 AGE (in years last birthday)		7 UNDER 24 HRS.	
Male		Caucasion		July 12, 1894		74 YRS.		MONTHS DAYS HRS. MIN.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH			
Lithuania		U.S.A.				Montgomery Md.			
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUA. OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY
Bethesda			Conv. Center Grosvenor Lane Nursing & Self Employed-Rest.						
13a USUAL RESIDENCE (Where deceased admission) STATE		13b. COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
Hyattsville, Md.		Prince Geo. Co.		Hyattsville				1434 Kanawha St.	
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME						
First Middle Last Herman I. Breakstone			First Middle Last Deborah Gotthelt						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO		17 INFORMANT Address				
No					Frieda Breakstone - Wife 1434 Kanawha St. Hyattsville, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))									
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) cardiac arrest									
DUE TO, OR AS A CONSEQUENCE OF (b) Atherosclerotic Cardiovascular disease									
DUE TO, OR AS A CONSEQUENCE OF (c) Diabetes mellitus									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
MEDICAL CERTIFICATION									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC		21f LOCATION Street or R.F.D. No		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from May, 1968, to July, 1968, that (I) (we) last saw the deceased alive on July 20, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE					22c DATE SIGNED				
Walter Goozth MD					7/22/68				
22d PHYSICIAN'S NAME (Type)					22e ADDRESS				
WALTER GOOZTH MD					2309 SHOREFIELD RD WHEATON MD				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		July 23, 1968		Washington Cemetery		Brooklyn, New York			
24 FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Donald M. Stein				232 Carroll		JUL 23 1968			
Hebrew Memorial Funeral Home St., N.W. Wash., D.C.						Charles Judge			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

10139

10150

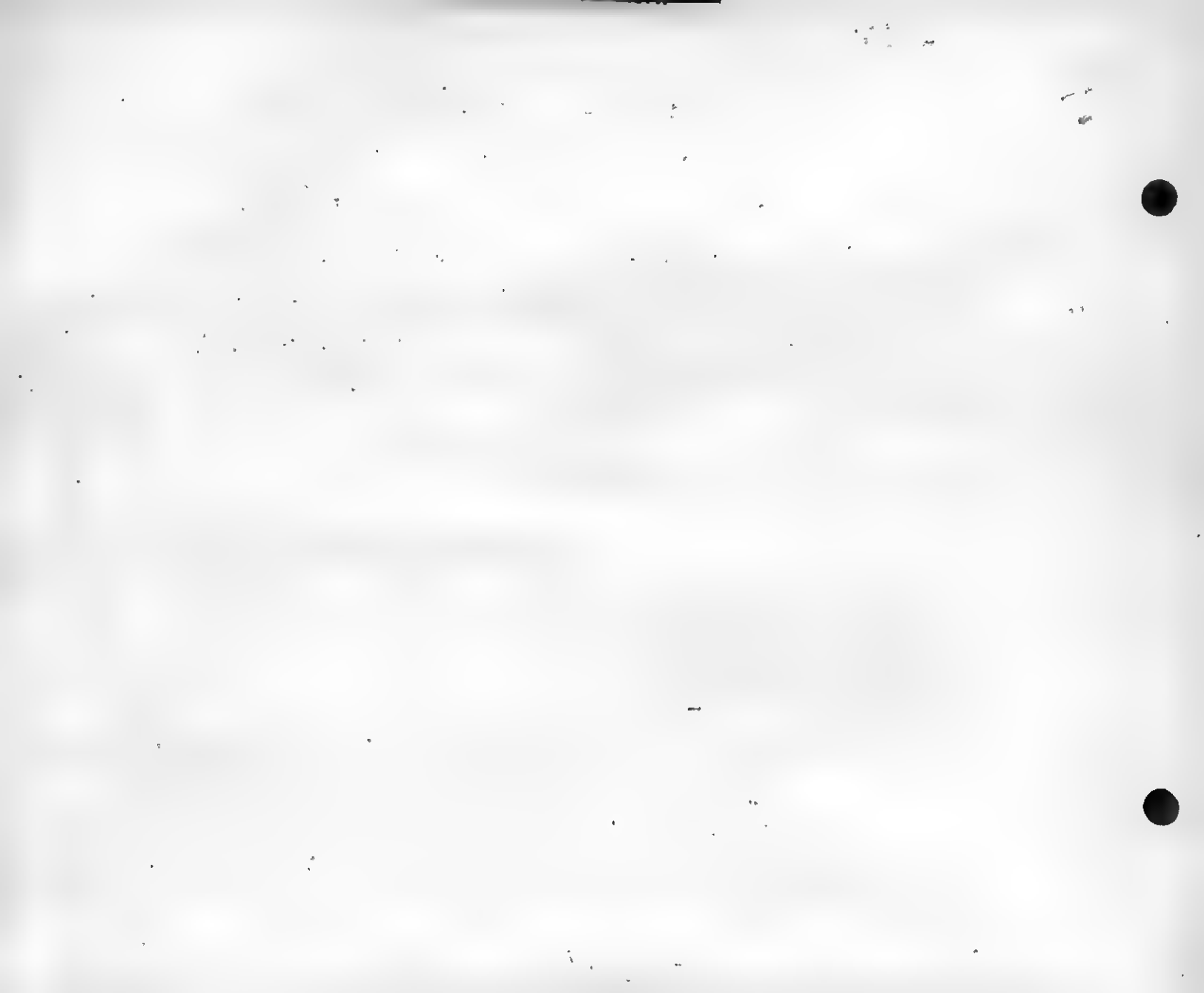
1 DECEASED-NAME (Type or print) First Middle Last Mrs. Bertha M Brittain				2a. DATE OF DEATH Month Day Year 7 13 1968		2b. HOUR 12 ³⁰ A.M.	
3 SEX Female		4 RACE White		5 DATE OF BIRTH 3/4/85		6 AGE (In years lost birthday) 83 YRS.	
7a BIRTHPLACE (State or foreign country) D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> D.VORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.	
10 CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Holy Cross Hosp.		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Own Home	
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Md.		13b. COUNTY Montgomery		13c CITY OR TOWN Silver Spring		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e STREET AND NUMBER 1719 Luzerne Avenue		14 FATHER'S NAME First Middle Last David M. Crown		15. MOTHER'S MAIDEN NAME First Middle Last Nattie R. Keating		16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No	
16b SOCIAL SECURITY NO 220-54-1633		17 INFORMANT Marian R. Royster		1719 Luzerne Ave. Silver Spring, Md.		18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage 4120 DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic-hypertensive cardio-vascular disease DUE TO, OR AS A CONSEQUENCE OF (c) — PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) None	
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State		22a. I certify that (I) (this hospital) attended the deceased from Mar 1956, to July 13, 1968, that (I) (we) last saw the deceased alive on July 12, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b SIGNATURE William F. Simpson MD - DEGREE 22c DATE SIGNED 7/13/68	
22d. PHYSICIAN'S NAME (Type) William F. Simpson MD		22e ADDRESS 6216 N.H. Ave NE - DC 20011		23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE July 16, 1968	
23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery		23d. LOCATION (City or Town) (County) (State) Silver Spring, Md.		24 FUNERAL DIRECTOR Warner E. Humphrey, Inc.		25a REC'D BY REGISTRAR JUL 18 1968	
25b REGISTRAR'S SIGNATURE Charles Judge		25c ADDRESS 8434 Georgia Ave. Silver Spring, Md.		25d DATE JUL 18 1968		25e SIGNATURE Charles Judge	



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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED NAME (Type or print) <i>Lillian Cecilia Brode</i>						2a. DATE OF DEATH Month <i>July</i> Day <i>21</i> Year <i>1968</i>			2b. HOUR <i>2 P.M.</i>		
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>10-22-1915</i>		6. AGE (In years last birthday) <i>53</i> YRS		F UNDER 1 YEAR MONTHS <i>7</i> DAYS <i>10</i>		IF UNDER 24 HRS. HOURS <i>2</i> MIN <i>15</i>	
7a. BIRTHPLACE (State or foreign country) <i>Virginia</i>		7b. CITIZEN OF WHAT COUNTRY? <i>American Citizen</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i> Md.					
10. CITY OR TOWN OF DEATH <i>Takoma Park</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Washington Sanitarium - Hospital</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) STATE <i>Washington D.C.</i>		13b. COUNTY <i>Washington D.C.</i>		13c. CITY OR TOWN <i>Washington D.C.</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>1230 13th Street N.W.</i>			
14. FATHER'S NAME First <i>James</i> Middle <i>Pullman</i> Last <i>Pullman</i>				15. MOTHER'S MAIDEN NAME First <i>Lillian</i> Middle <i>Whittington</i> Last <i>?</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, No, or unknown) <i>No</i> (If yes give war or dates of service)				16b. SOCIAL SECURITY NO. <i>XXXXXXXXXX 447-09-24070</i>		17. INFORMANT <i>Records - Washington Sanitarium - Hospital</i> Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Pulmonary Edema</i> <i>4d70</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a). <i>CHF</i> stating the underlying cause last. (b) <i>CHF</i> DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2-3 days</i> <i>5-6 days</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Malnutrition and Anemia</i>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. If YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, CORNER BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <i>7/11</i> , 19 <i>68</i> , to <i>7-21</i> , 19 <i>68</i> , that (I) (we) lost the deceased alive on <i>7-21</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>R.H. Sandstrom M.D.</i>		DEGREE <i>M.D.</i>		ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>7-21-68</i>	
22d. PHYSICIAN'S NAME (Type) <i>R.H. Sandstrom M.D.</i>		22e. ADDRESS <i>7701 Carroll Ave TRK, MD</i>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>7/24/68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Sharon Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Alexandria, Virginia</i>					
24. FUNERAL DIRECTOR <i>Murphy Funeral Home,</i>		ADDRESS <i>3524 Columbia Pike</i>		25a. REC'D BY REGISTRAR DATE <i>JUL 23 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					



Health prior to burial, cremation, or removal, and in any event within 72 hours after death

VR A15ME (S)
10M REV 1/68

<div style="display: flex; justify-content: space-between;"> 19141 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 10454 </div> <h2 style="margin: 0;">MEDICAL EXAMINER'S CERTIFICATE OF DEATH</h2>											
1 DECEASED-NAME (Type or Print) First Middle Last MARY ROYALL XXXX BROWN						2a DATE KNOWN OF DEATH Month <input checked="" type="checkbox"/> Day 7-17 Year 1968			2b HOUR 7:48 AM		
3 SEX female	4 RACE cauc.	5 DATE OF BIRTH 11/24/84	6 AGE (In years last birthday) 83 YRS	7 IF UNDER 1 YEAR MONTHS 0 DAYS 0	7 IF UNDER 24 HRS HOURS 0 MIN 0	2c DATE PRONOUNCED DEAD Month 7 Day 17 Year 1968			2d HOUR 7:10A		
7a BIRTHPLACE (State or foreign country) Virginia		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Montgomery County, Md					
10 CITY OR TOWN OF DEATH Silver Spring			11 NAME OF HOSPITAL OR INSTITUTION (If not a hospital give name of place where deceased died) Holy Cross Hospital of S.S. Landady			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Landady			12b KIND OF BUSINESS OR INDUSTRY Boardinghouse		
13a U.S.A. RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland				13b COUNTY Montgomery	13c CITY OR TOWN Silver Spring	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET AND NUMBER 12921 Old Columbia Pike				
14 FATHER'S NAME First Saunders Middle Saunders Last Saunders						15 MOTHER'S MAIDEN NAME First Not Available Middle Not Available Last Not Available					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes give war or dates of service)			16b SOCIAL SECURITY NO. 577-48-3917			17 INFORMANT ADDRESS Paul Leguin-same as above- nephew					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Coronary Insufficiency 4124 DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerotic Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) 1201											
19a DATE OF OPERATION 1201				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year HOUR 19 A.M. 19 P.M.		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)							
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No		City or Town		County		State	
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Belden R. Keap M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b DATE SIGNED July 17, 1968			
EXAMINER'S NAME (Type) BELDEN R. KEAP, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				22c MEDICAL EXAMINER'S ADDRESS (Street, City, Town, or County) 254 Carroll HNW			
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE July 22, 1968		23c NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		23d LOCATION (City or Town) (County) (State) Colmar Manor Md					
24 CLERICAL DIRECTOR J. H. H. H. H. H.				ADDRESS 254 Carroll HNW		25a REC'D BY REGISTRAR JUL 18 1968		25b REGISTRAR'S SIGNATURE J. Charles Judge			

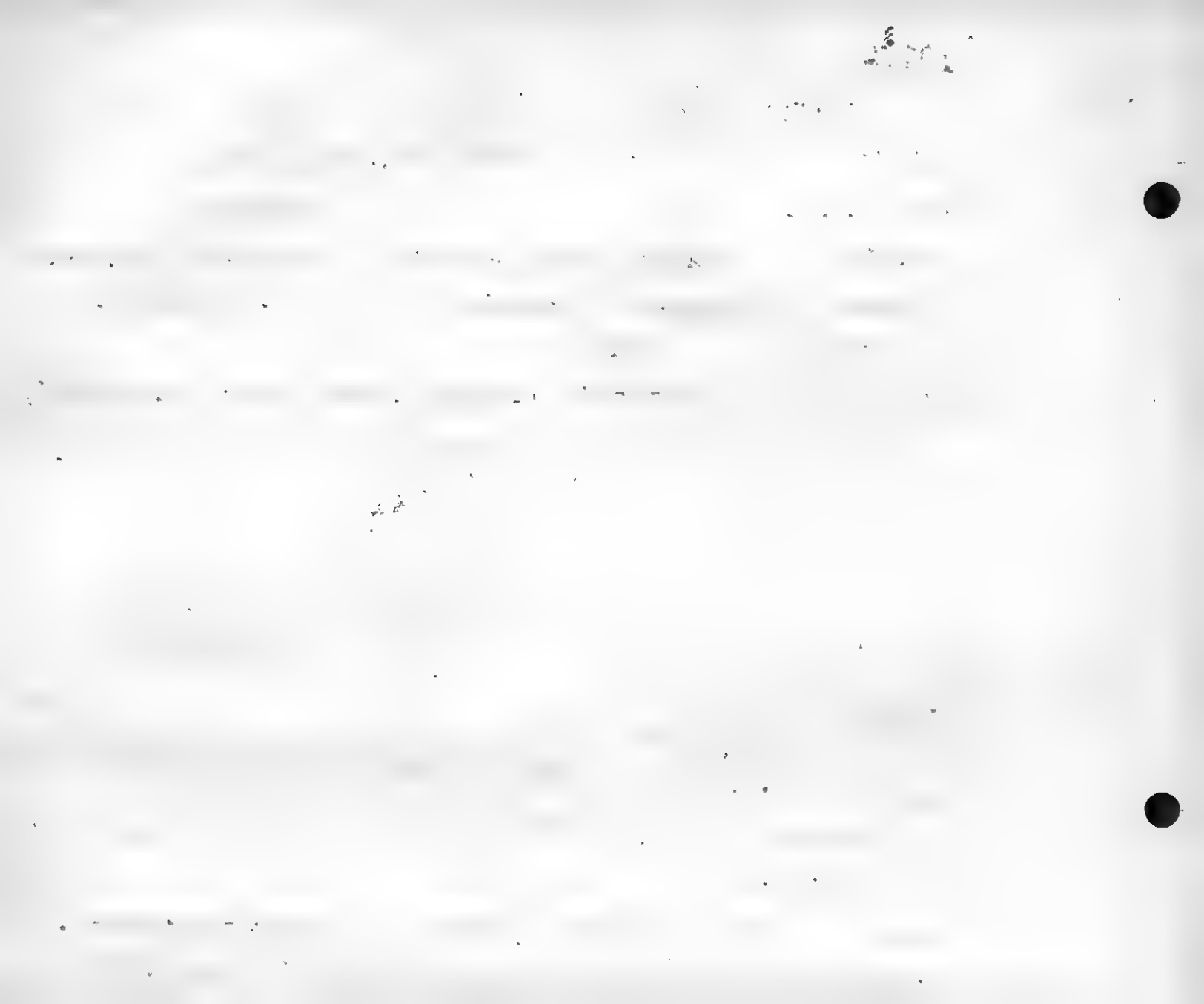
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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH	2b. HOUR	
Mitchell Mayden				Brown	July 8 Day 1968	5:00 P.M.	
3 SEX	4. RACE	5. DATE OF BIRTH		6. AGE (In years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS	
Male	White	November 20, 1885		82 YRS.	MONTHS	DAYS	
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Jefferson Co., W. Va.	USA			Montgomery Md.			
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY		
Kensington	Kensington Gardens Sanatorium		Stock clerk		Whol. Grocery		
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER			
Maryland	Washington	Hagerstown	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	564 W. Washington St.			
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		
William			Brown		Frances		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)		16b. SOCIAL SECURITY NO		17. INFORMANT			
No		214-09-9113A		Mr. Russell W. Brown 10 Harvard Rd. Hagerstown, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Thrombosis						9 days	
4109 DUE TO, OR AS A CONSEQUENCE OF							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last							
DUE TO, OR AS A CONSEQUENCE OF (b)							
DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
Arteriosclerosis - Emphysema							
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
None	None		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		None		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)			
None		None		None			
21d. INJURY OCCURRED While <input type="checkbox"/> AND while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State				
None		None		None			
22a. I certify that (I) (this hospital) attended the deceased from September 29, 1967, to July 8, 1968, that (I) (we) last saw the deceased alive on July 3, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE			22c. DATE SIGNED		22d. PHYSICIAN'S NAME (Type)		
James M. Loftis M.D.			July 8, 1968		James M. Loftis		
22e. ADDRESS			22f. ADDRESS				
James M. Loftis			James M. Loftis				
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial	7/11/68	Rest Haven Cemetery		Hagerstown-Washington-Md.			
24. FUNERAL DIRECTOR		ADDRESS		25a. FILED BY REG. STAFF		25b. REGISTRAR'S SIGNATURE	
Hester & Sons		1011 Penna Ave Hagerstown		JUL 10 1968		James M. Loftis	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print) Lucille Mary Bryan			2a. DATE OF DEATH Month 7 Day 1 Year 68			2b. HOUR 2:25 PM			
3. SEX Female		4. RACE White		5. DATE OF BIRTH 9-1-18		6. AGE (In years lost birthday) 49 YRS			
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.			
10. CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Wash. San. + Hosp		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) housewife		12b. KIND OF BUSINESS OR INDUSTRY home			
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland			13b. COUNTY Laurel		13c. CITY OR TOWN Laurel		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
13e. STREET AND NUMBER RFD 2, Box 121									
14 FATHER'S NAME First Robert Middle Rickets Last Lena			15. MOTHER'S MAIDEN NAME First Lena Middle Speck Last Speck						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. 218-38-939x		17 INFORMANT Hospital Record			Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Malignant Brain Tumor 238F DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) none									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No: City or Town County State					
22a. I certify that (1) (this hospital) attended the deceased from April , 19 68 , to July 1 , 19 68 , that (1) (we) last saw the deceased alive on June 30 , 19 68 , and that in (1) (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Joseph E. Smith, Jr.				22c. DATE SIGNED M.D.		22d. PHYSICIAN'S NAME (Type) Joseph E. Smith, Jr.			
22e. ADDRESS Bartonsville, Md.									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 7-3-68		23c. NAME OF CEMETERY OR CREMATORY Mt. Carmel		23d. LOCATION (City or Town) (County) (State) Sunshine Mont. Md.			
24 FUNERAL DIRECTOR Francis H. Barber				ADDRESS Laytonsville, Md.		25a. REC'D BY REGISTRAR JUL - 3 1968		25b. REGISTRAR'S SIGNATURE J. Charles Judge	



FOR STATE
HEALTH DEPT.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or Print) Charles		First U.		Middle		Last Buck		2a DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MATED 7/13/68		Month 19 Day 11 Year P M	
3 SEX Male	4 RACE wh.	5 DATE OF BIRTH 8/31/1887	6 AGE (In years last birthday) 80 YRS	F UNDER 1 YEAR MONTHS 0 DAYS 0		IF UNDER 24 HRS HOURS 0 MIN 0		2c DATE PRONOUNCED DEAD Month 7 Day 13 Year 19 68		2d HOUR 11 P	
7a BIRTHPLACE (State or foreign country) Nebraska		7b CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Montgomery Md.					
10. CITY OR TOWN OF DEATH Silver Spring,		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Holy Cross Hospital				12a USUAL OCCUPATION (Kind of work done during most of working life even if retired) Retired		12b KIND OF BUSINESS OR INDUSTRY			
13a USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE Wash. DC		13b COUNTY Wash. DC		13c CITY OR TOWN Wash. DC		13d INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e STREET AND NUMBER 109 Longfellow St. NW			
14. FATHER'S NAME GEORGE		First BUCK.		Middle		Last		15 MOTHER'S M.A.DEN NAME ANNIE		First FEATHERAGE	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, but not known) YES		16b. SOCIAL SECURITY NO		17. INFORMANT MARION BUCK.		ADDRESS 109 Longfellow St. N.W.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Congestive Heart Failure due to 004X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (c) stating the underlying cause last (b) Arteriosclerotic Heart Disease complicated DUE TO, OR AS A CONSEQUENCE OF (c) by trauma incurred in fall at home											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 402.0											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
21a EXTERNAL CAUSE WAS PR MARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b TIME OF INJURY Month Day Year HOUR A.M. 7-2-68 P.M.		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B) deceased fell out of bed at home & fractured l. femur							
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Home		21f LOCATION Street or R.F.D. No 109 Longfellow St, Washington		City or Town		County		State D. C.	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Beiden R. Reap		EXAMINER'S NAME (Type) BEIDEN R. REAP M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b DATE SIGNED July 14 1968	
23a BURIAL CREMATION REMAINS (Specify)		23b DATE July 17-1968		23c NAME OF CEMETERY OR CREMATORY St. Lincoln Cemetery		23d LOCATION (City or Town) Bladensburg R. Co. Md.		County		State	
24 FUNERAL DIRECTOR Arthur Walters		ADDRESS 25 Carroll St		25a RECD BY REGISTRAR Charles Judge		25b REGISTRAR'S SIGNATURE		DATE JUL 17 1968			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

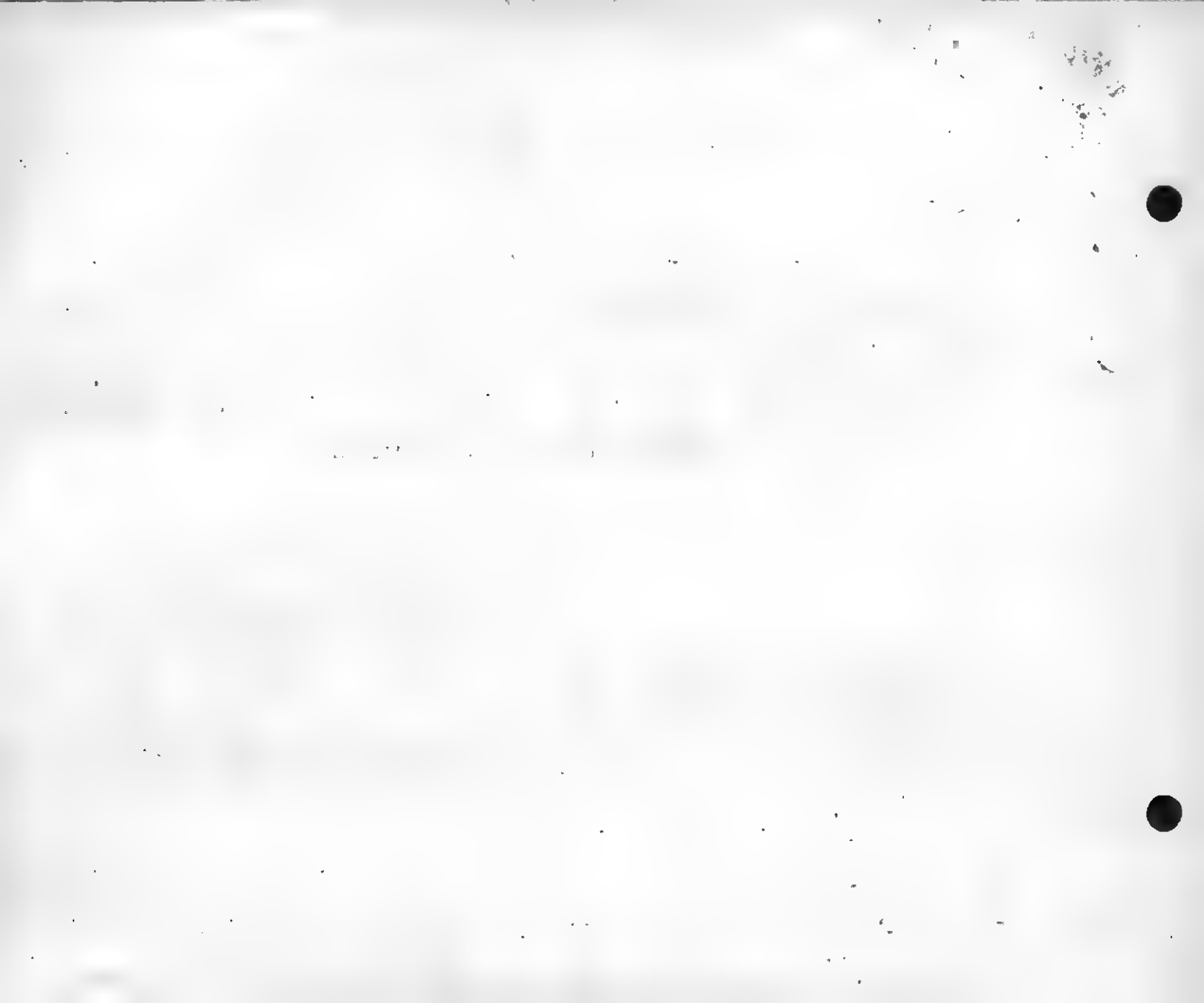
1 DECEASED NAME (Type or Print)			First	Middle	Last	2a DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month Day Year			2b HOUR
Harry Pratt Buckley						JULY 18 1968			11 PM
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	7 UNDER 1 YEAR MONTHS DAYS		8 IF LATER 24 HRS HOURS MIN.		2c DATE PRONOUNCED DEAD Month Day Year	2d HOUR
Male	White	7/19/16	51	1				JULY 18 1968	11 PM
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH		Md	
Gratersford Pa.		U.S.A.				Mont.			
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b KIND OF BUSINESS OR INDUSTRY			
Bethesda		4242 East West Highway		accountant		US Gov't			
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER
Md.			Mont.		Bethesda		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		4242 East West Highway
14 FATHER'S NAME First Middle Last			15 MOTHER'S MAIDEN NAME First Middle Last						
Harry Pratt Buckley			Rosa Whitman						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SECURITY NO.		17 INFORMANT		ADDRESS		
			184-09-4057		Charlotte Buckley		4242 East West Highway		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Insufficiency Acute.									Sudden.
DUE TO, OR AS A CONSEQUENCE OF									
Condit ans, if any, which gave rise to immediate cause (a), stating the underlying cause last									
(b) Cardio Vascular Disease.									years
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PR MARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B)				
			19						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No		City or Town		County	State
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE			EXAMINER'S NAME (Type)			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED	
John G. Ball			John G. Ball			ASS. STANT MEDICAL EXAMINER <input type="checkbox"/>		JULY 19, 1968	
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
						ADDRESS (Street, city, town, or county)			
23a. BURIAL (CREMATION, REMOVAL) (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		7/22/68		Schwenksville Cem.		Schwenksville Montgom. P.			
24. FUNERAL DIRECTOR					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Robert A. Pumphrey 7557 Wisc. Ave. Balt. Md.					DATE JUL 24 1968		f Charles J. J...		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

10146										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										1968																																							
1. DECEASED-NAME (Type or print)										2a. DATE OF DEATH										2b. HOUR																																							
MICHAEL S BURCH										JULY 14 1968										10 45 AM																																							
3. SEX										4. RACE										5. DATE OF BIRTH										6. AGE (In years lost birthday)										IF UNDER 1 YEAR MONTHS										IF UNDER 24 HRS. HOURS MIN.									
MALE										WHITE										JULY 9, 1968										YRS.										5 18 25																			
7a. BIRTHPLACE (State or foreign country)										7b. CITIZEN OF WHAT COUNTRY?										8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										9. COUNTY OF DEATH																													
MD.										USA																				MONTGOMERY CTY										Md																			
10. CITY OR TOWN OF DEATH										11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)										12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)										12b. KIND OF BUSINESS OR INDUSTRY																													
SILVER SPRING										HOLY CROSS HOSP.																																																	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE										13b. COUNTY										13c. CITY OR TOWN										13d. INSIDE CITY LIMITS?										13e. STREET AND NUMBER																			
VA										Louisa										STERLING										YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										4110 REDWOOD RD.																			
14. FATHER'S NAME										15. MOTHER'S MAIDEN NAME																																																	
JAY D BURCH										GLENDA RUSSELL																																																	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)										16b. SOCIAL SECURITY NO										17. INFORMANT										Address																													
NO										NONE										GLENDA R. BURCH										910 REDWOOD RD. STERLING, VA																													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))																														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																													
PART 1 DEATH WAS CAUSED BY:																																																											
IMMEDIATE CAUSE (a)										BRONCHOPNEUMONIA, BILATERAL																																																	
480 X										DUE TO, OR AS A CONSEQUENCE OF																																																	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										(b)										DUE TO, OR AS A CONSEQUENCE OF																																							
										(c)																																																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																																																											
763																																																											
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY?										20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																													
																				YES <input type="checkbox"/> NO <input type="checkbox"/>																																							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b. TIME OF INJURY										21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																																							
										HOUR A.M. Month Day Year																																																	
21d. INJURY OCCURRED										21e. PLACE OF INJURY (AT HOME FARM STREET, FACTORY, OFFICE BUILDING, ETC.)										21f. LOCATION										City or Town										County										State									
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>																				Street or R.F.D. No.																																							
22a. I certify that (I) (this hospital) attended the deceased from 7/14, 1968, to 7/14, 1968, that (I) (we) last saw the deceased alive on 7/14, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																																																											
22b. SIGNATURE										22c. DATE SIGNED																																																	
S. BATTIATA										7/15/68																																																	
22d. PHYSICIAN'S NAME (Type)										22e. ADDRESS																																																	
										1000 Lebanon St 55th																																																	
23a. BURIAL CREMATION, REMOVAL (Specify)										23b. DATE										23c. NAME OF CEMETERY OR CREMATORY										23d. LOCATION (City or Town) (County) (State)																													
REMOVAL-BURIAL 7-16-68										GREEN FUNERAL HOME										CHESTNUT GROVE CEMETERY, HERNDON, VIRGINIA																																							
24. FUNERAL DIRECTOR										25a. REC'D BY REGISTRAR										25b. REGISTRAR'S SIGNATURE																																							
J. Buckley Green - 34 Eldon St., Herndon, VA.										JUL 18 1968										J. Charles Judge																																							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) Hazel M. BURESH			2a. DATE OF DEATH July Month 26 Day Year 68			2b. HOUR 759A			
3. SEX Female		4 RACE Caucasian		5 DATE OF BIRTH Oct. 9, 1908		6 AGE (In years last birthday) 59 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a BIRTHPLACE (State or foreign country) Florida		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Montgomery Md.			
10. CITY OR TOWN OF DEATH Bethesda		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Naval Hospital		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife		12b KIND OF BUSINESS OR INDUSTRY			
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Florida		13b COUNTY Mims		13c CITY OR TOWN Mims		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER P. O. Box 692	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last Eva McManus						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) NO		16b. SOCIAL SECURITY NO. (If yes give year or dates of service)		17 INFORMANT Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory obstruction</u> <u>1621</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Carcinoma Lung</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>163x</u>									
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) (OFFICE, BUILDING, ETC)		21f. LOCATION Street or R.F.D. No		City or Town		County State	
22a. I certify that (b) (this hospital) attended the deceased from <u>July 20, 1968</u> , to <u>July 26, 1968</u> , that (b) (we) last saw the deceased alive on <u>July 26, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (b) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>W. Dallas Hall, Jr.</u>		DEGREE		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED July 26, 1968			
22d. PHYSICIAN'S NAME (Type) W. Dallas Hall, Jr., M. D.		22e. ADDRESS Naval Hospital, Bethesda, Md.							
23a BURIAL, CREMATION, REMOVAL: (Specify) Burial		23b DATE 7-29-68		23c NAME OF CEMETERY OR CREMATORY Bevard Memorial Cemetery		23d LOCATION (City or Town) Titusville,		(County) (State) Fla.	
24 FUNERAL DIRECTOR Robert A. Pumphrey Funeral Home, 7557 Wisconsin Ave., Bethesda, Md.				25a. REC'D BY REGISTRAR DATE <u>JUL 31 1968</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

10148

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

159

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type, or print) First Middle Last VIRGINIA I BURKE			2a. DATE OF DEATH Month Day Year JULY 14 1968			2b. HOUR 5:35 M	
3. SEX F		4. RACE WHITE		5. DATE OF BIRTH May 29 1910		6. AGE (In years lost birthday) 58 YRS.	
7a. BIRTHPLACE (State or foreign) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH MONTGOMERY Md.	
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SUBURBAN		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HOUSE-WIFE		12b. KIND OF BUSINESS OR INDUSTRY	
13a. U.S.A. RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MARYLAND		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN CABIN JOHN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME First Middle Last Manuel L. Randis		15. MOTHER'S MAIDEN NAME First Middle Last Maria E. Bell		13e. STREET AND NUMBER 6525-75th St NW			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16b. SOCIAL SECURITY NO. 212-14-5657		17. INFORMANT Robert Burke		Address same as above	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) UREMIA + DIABETIC COMA DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last 401X (b) HYPERTENSION + DIABETES DUE TO, OR AS A CONSEQUENCE OF (c) ARTERIO SCLEROSIS							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 DAYS 10 YRS GRADUAL
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from JAN 1965 , to JULY 12, 1968 , that (I) (we) last saw the deceased alive on JULY 14, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Dr. Leo Donovan				DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 7/14/68	
22d. PHYSICIAN'S NAME (Type) DR LEO DONOVAN				22e. ADDRESS 8218 WILCOXIN AVE BETHESDA			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 7-17-68		23c. NAME OF CEMETERY OR CREMATORY Potomac Methodist		23d. LOCATION (City or Town) (County) (State) Potomac Mont. Md	
24. FUNERAL DIRECTOR Robert A Pumphrey				ADDRESS 7557 Wisconsin Ave Bethesda Md		25a. REC'D BY REGISTRAR JUL 16 1968	
						25b. REGISTRAR'S SIGNATURE J. Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal; and in any event, within 72 hours after death.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) EDWARD LOUIS BUSER			2a. DATE OF DEATH Month 7 - Day 17 - Year 1968			2b. HOUR 11:54 A M	
3. SEX MALE		4 RACE WHITE		5 DATE OF BIRTH 2/28/1885		6 AGE (In years last birthday) 83 YRS.	
7a. BIRTHPLACE (State or foreign country) PA.		7b. CITIZEN OF WHAT COUNTRY? U.S.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH MONTGOMERY Md.	
10 CITY OR TOWN OF DEATH SILVER SPRING		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) COLONIAL VILLA NURSING HOME		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) CARPENTER		12b. KIND OF BUSINESS OR INDUSTRY Carpentry	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE MARYLAND		13b. COUNTY MONT.		13c. CITY OR TOWN SILVER SPRING		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 1509 BALLARD STREET		14. FATHER'S NAME First Middle Last Louis A. Buser		15 MOTHER'S MAIDEN NAME First Middle Last Florence Diffenderfer			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b. SOCIAL SECURITY NO. 189-10-6040 A		17 INFORMANT THE PATIENT		Address 1509 Ballard Street, Silver Spring, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) UREMIA 186 X DUE TO, OR AS A CONSEQUENCE OF (b) ADENOCARCINOMA OF PROSTATE DUE TO, OR AS A CONSEQUENCE OF (c) WITH METASTASIS							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 MONTHS 21 MONTHS
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 177 X CONGESTIVE HEART FAILURE							
19a. DATE OF OPERATION JUNE 1968		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED ADENOC PROSTATE TUR		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? -	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) at work		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (the hospital) attended the deceased from 7-13 , 19 67 , to 7-17 , 19 68 , that (I) (we) last saw the deceased alive on 7-16 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE James A. Roberts				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 7-17-68	
22d. PHYSICIAN'S NAME (Type) JAMES A. ROBERTS				22e. ADDRESS 8907 GEO. AVE. SILVER SPRING, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE July 22, 1968		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		23d. LOCATION (City or Town) (County) (State) Prince George's Co., Md.	
24. FUNERAL DIRECTOR Warner C. Humphrey, Inc.		ADDRESS 8434 Georgia Ave. Silver Spring, Md.		25a. REC'D BY REGISTRAR JUL 24 1968		25b. REGISTRAR'S SIGNATURE Charles J. [Signature]	



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 10-101, Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

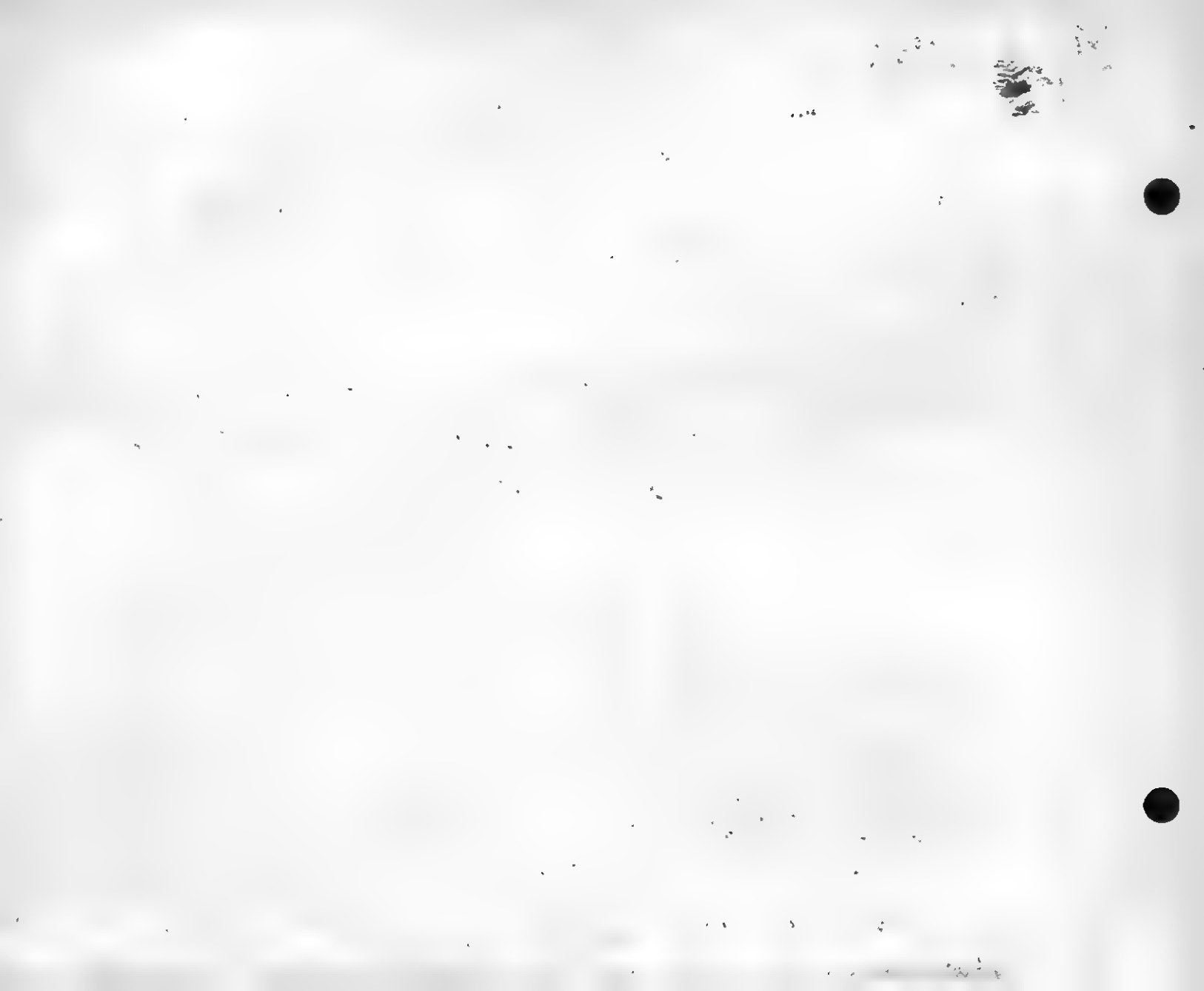
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1 DECEASED NAME (Type in print)			First Middle Last			2a DATE KNOWN OF DEATH			Month Day Year		
ANNIE GERTRUDE			BYRNE			7-18			1968		
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years)	7 UNDER 1 YEAR	8 UNDER 24 HRS	2c DATE PRONOUNCED DEAD			Month Day Year		
Fe	Cauc	Feb. 15 1892	76 YRS			7-18			1968		
7a BIRTHPLACE (State or foreign country)			7b C. T. ZONE OF WHAT COUNTRY?			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH		
Silver Spring			U. S. A.			Montgomery			Md		
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY		
Silver Spring			15915 Littleboro Rd.			Housewife					
13a USUAL RESIDENCE (Where deceased lived if institution Residence before admission) STATE			13b COUNTY			13c CITY OR TOWN			13d INS DE CITY LIM 157		
VA.			Prince Wm.			CATHARPIN			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME			16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SECURITY NO.		
Charles Edwin			Margaret Ella			No			231-62-9693		
17 INFORMANT			18 ADDRESS			19a CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
Raymond Byrne						PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Coronary Insufficiency					
						DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Heart Disease					
						DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY?			
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b TIME OF INJURY Month, Day, Year				21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
				19 P.M.							
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
22b. DATE SIGNED				22c. NAME OF MEDICAL EXAMINER				22d. LOCATION (City or Town) (County) (State)			
July 18, 1968				Belden R. Reap M.D.				Middleburg Loudoun, VA.			
23a BURIAL, CREMATION, REMOVAL (Specify)				23b DATE				23c NAME OF CEMETERY OR CREMATORY			
Burial				July 21, 1968				Middleburg Va. Mem. Cem.			
24. FUNERAL DIRECTOR				25a REC'D BY REGISTRAR				25b REGISTRAR'S SIGNATURE			
Norris Royston				JUL 24 1968				Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) Domenico			First Middle Last			2a. DATE OF DEATH Month 7 Day 14 Year 68			2b. HOUR 5:15 A.M.								
3 SEX male			4. RACE white			5. DATE OF BIRTH 2/1/90			6 AGE (in years last birthday) 78 YRS.			IF UNDER 1 YEAR MONTHS DAYS			IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) Italy			7b. CITIZEN OF WHAT COUNTRY? U.S.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Montgomery Co. Md.								
10. CITY OR TOWN OF DEATH Takoma Park			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Wash. San + Hosp.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Shoe maker			12b. KIND OF BUSINESS OR INDUSTRY								
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE District of Columbia			13b. COUNTY			13c. CITY OR TOWN Wash., D.C.			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER 349 Cedar St., N.W.					
14. FATHER'S NAME Venerando			First Middle Last			15. MOTHER'S MAIDEN NAME TEDESCO			First Middle Last								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) unknown			16b. SOCIAL SECURITY NO. 578-48-4867			17. INFORMANT GIOVANNI CAFFO			Address 1034 N. TAYLOR ST. ARLINGTON VA.								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL VASCULAR THROMBOSIS 2509 DUE TO, OR AS A CONSEQUENCE OF (b) DIABETIS MELLITUS DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 9 DAYS					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State											
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE Walter Goodrich			DEGREE			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED								
22d. PHYSICIAN'S NAME (Type) WALTER GOODRICH MD			22e. ADDRESS														
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE 19 JULY 1968			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State) CATANIA ITALY								
24. FUNERAL DIRECTOR RINALDI FUNERAL HOME			ADDRESS 7400 GEORGIA AVE, N.W. DC			25a. REC'D BY REGISTRAR AUG 18 1968			25b. REGISTRAR'S SIGNATURE J. Charles Judge								



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Page 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with the death certificate. Pages 1 and 2 with the death certificate should be retained for your files.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED NAME (Type or Print)			First William			Middle David			Last CALHOUN			2a. DATE KNOWN OF ESTI- DEATH MATED <input type="checkbox"/> Month Day Year			2b. HOUR 9:38 PM		
3. SEX Male		4. RACE Cauc		5. DATE OF BIRTH 25 Dec 43		6. AGE (In years last birthday) 25 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		2c. DATE PRONOUNCED DEAD Month July Day 28 Year 19 68			2d. HOUR 9:38 PM		
7a. BIRTHPLACE (State or foreign country) Michigan				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> W DOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH Montgomery Md.					
10. CITY OR TOWN OF DEATH Bethesda				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Naval Hospital				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) U.S. Navy				12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Michigan				13b. COUNTY Huntington Woods				13c. CITY OR TOWN YES <input type="checkbox"/> NO <input type="checkbox"/>				13d. STREET AND NUMBER 10543 Talbot Road					
14. FATHER'S NAME First Middle Last David Ross Calhoun						15. MOTHER'S M A DEN NAME First Middle Last Blanche Lyle Galloway											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> 1968-68						16b. SOCIAL SECURITY NO. 364 42 2436						17. INFORMANT Navy Records					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Branchial Pneumonia. Bilateral</u> DUE TO OR AS A CONSEQUENCE OF (b) <u>2nd & 3rd degree burns of 75% of body</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>15 days</u>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>15 days</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																	
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>						21b. TIME OF INJURY Month, Day Year 8:34 PM July 16 68						21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) <u>Fighting a furnace and exploded</u>					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>						21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <u>Home</u>						21f. LOCATION Street or RFD No City or Town County State <u>Route 249 Lexington Park St Marys Md.</u>					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>																	
ACTUAL SIGNATURE <u>John G. Ball</u>						CHIEF MEDICAL EXAMINER <input type="checkbox"/>						22b. DATE SIGNED 29 July 1968					
EXAMINER'S NAME (Type) John G. Ball, M. D.						DEPUTY MED. CA. EXAMINER <input checked="" type="checkbox"/>						ADDRESS (Street, city, town or county)					
23a. BURIAL CREMATION, REMOVAL (Specify) Burial				23b. DATE 8-2-1968				23c. NAME OF CEMETERY OR CREMATORY White Chapel Memorial Cemetery				23d. LOCATION (City or Town) (County) (State) Detroit Mich.					
24. FUNERAL DIRECTOR W. W. Chambers Co. ADDRESS 1400 Chapin Street, N. W., Washington, D. C.										25a. RECEIVED BY REGISTRAR DATE <u>109 SEP 3 1968</u>				25b. REGISTRAR'S SIGNATURE <u>John G. Ball</u>			

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED NAME (Type or Print) CHARLES Herbert CARLE			2a DATE KNOWN OF DEATH 7-25-68		2b HOUR 68
3 SEX M	4 RACE CAUC.	5 DATE OF BIRTH Sept. 29, 1899	6 AGE (in years last birthday) 68 YRS.	7 UNDER 1 YEAR MONTHS 7 DAYS 25	IF UNDER 24 HRS. HOURS 19 MIN 68
7a BIRTHPLACE (State or foreign country) New York		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9a CITY OR TOWN OF DEATH SILVER SPRING			9b COUNTY OF DEATH Montgomery		
10 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) 109 Forest Glen Rd.			11a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Retired - U.S. Post Office		
12a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE M.D.			12b KIND OF BUSINESS OR INDUSTRY Office		
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE M.D.			13b COUNTY MONTGOMERY S.S.		
14 FATHER'S NAME First Jasen Middle - Last Carle			15 MOTHER'S MAIDEN NAME First Ellie Middle (Unknown) Last (Unknown)		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no			16b SOCIAL SECURITY NO. yes		
17 INFORMANT Mrs. Caroline R. Carle Silver Spring, Md.			18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Laceration of brain with exsanguination due to gunshot wound in head			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 955X			(b) Gunshot wound in head		
(c) 976X			PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)		
19a DATE OF OPERATION 7-25-68			19b CONDITION FOR WHICH OPERATION WAS PERFORMED? Deceased shot self in right temple with revolver		
20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH Deceased shot self in right temple with revolver		
21b TIME OF INJURY Month Day, Year 7-25 19 68			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18.) Deceased shot self in right temple with revolver		
21d INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Home		
21f LOCATION Street or R.F.D. No Forest Glen Rd City or Town Silver Spring County Montg State Md			22a I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		
22b DATE SIGNED July 25, 1968			23a BURL, CREMATION, REMOVAL (Specify) Burial		
23b DATE July 27, 1968			23c NAME OF CEMETERY OR CREMATORY Parklawn Cemetery		
23d LOCATION (City or Town) (County) (State) Rockville, Maryland			24 FUNERAL DIRECTOR'S NAME (Type) Warner E. Humphrey, Inc.		
25a REC'D BY REGISTRAR JUL 31 1968			25b REGISTRAR'S SIGNATURE Charles Judge		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

VR 414
30M REV. 10-68

10156										MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
CERTIFICATE OF DEATH																						
1. DECEASED NAME (Type or print) <i>Martin</i>					First Middle Last <i>Carpenter</i>					2a. DATE OF DEATH Month <i>July</i> Day <i>22</i> Year <i>1968</i>					2b. HOUR <i>5:20 PM</i>							
3. SEX <i>Male</i>			4. RACE <i>White</i>			5. DATE OF BIRTH <i>Feb. 1894</i>			6. AGE (In years last birthday) <i>74</i> YRS.			7. UNDER 1 YEAR MONTHS <i>5</i> DAYS <i>11</i>			8. UNDER 24 HRS. HOURS MIN.							
7a. BIRTHPLACE (State or foreign country) <i>Mass.</i>			7b. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <i>Montgomery</i>													
10. CITY OR TOWN OF DEATH <i>Rockville</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Potomac Valley Hosp. Home</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Dept. of labor</i>			12b. KIND OF BUSINESS OR INDUSTRY													
13a. USUAL RESIDENCE (Where deceased lived, if institution) STATE <i>Md.</i>			13b. COUNTY <i>Montgomery</i>			13c. CITY OR TOWN <i>Kensington</i>			13d. INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER <i>9809 Conn. Ave.</i>										
14. FATHER'S NAME First Middle Last <i>Adelbert Carpenter</i>					15. MOTHER'S MAIDEN NAME First Middle Last <i>Charlotte M. ?</i>																	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> or unknown <input type="checkbox"/>			16b. SOCIAL SECURITY NO. <i>217-52-5405</i>			17. INFORMANT <i>Jan Frances Dickey</i>			Address <i>9809 Conn Ave.</i>													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Septicemia</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 wks</i>												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										(b) <i>Chronic urinary tract infection</i> <i>8 wks.</i>												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Cerebrovascular thrombosis</i>																						
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?													
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No City or Town County State																
22a. I certify that (I) (this hospital) attended the deceased from <i>1964</i> , 19____, to <i>7/22/68</i> , 19____, that (I) (we) last saw the deceased alive on <i>7/22/68</i> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																						
22b. SIGNATURE <i>Henry C. Scruggs</i>			DEGREE <i>M.D.</i>			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED <i>7/22/68</i>													
22d. PHYSICIAN'S NAME (Type) <i>Henry C. Scruggs M.D.</i>			22e. ADDRESS <i>5413 Cedar Lane Bethesda Md.</i>																			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>			23b. DATE <i>7/25/68</i>			23c. NAME OF CEMETERY OR CREMATORY <i>Parklawn</i>			23d. LOCATION (City or Town) (County) (State) <i>Rockville Mont. Md.</i>													
24. FUNERAL DIRECTOR <i>Robert A. Pumphrey</i>										ADDRESS <i>7557 Wisconsin Ave. Bethesda, Md.</i>			25a. REC'D BY REGISTRAR DATE <i>JUL 29 1968</i>			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>						

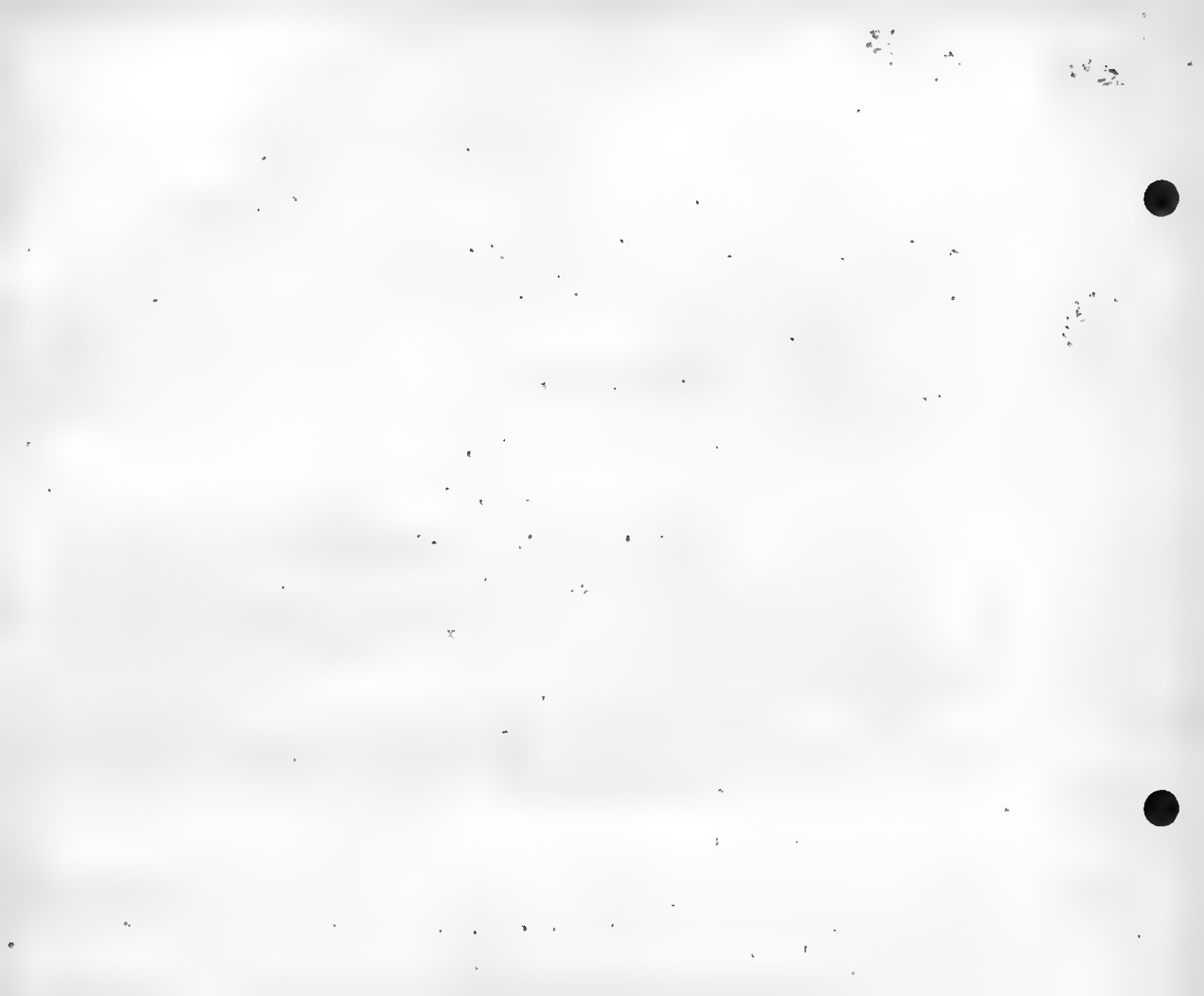
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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10153

CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) Zygmunt M			First Middle Last			2a. DATE OF DEATH Month Day Year July 18 1968			2b. HOUR 12:26 A M		
3 SEX male			4 RACE W			5 DATE OF BIRTH 8/10/03			6 AGE (In years lost birthday) 64		
7a. BIRTHPLACE (State or foreign country) Poland			7b. CITIZEN OF WHAT COUNTRY? French			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Montgomery		
10. CITY OR TOWN OF DEATH Bethesda			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Suburban Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) TRUCK CONSULTANT			12b. KIND OF BUSINESS OR INDUSTRY SELF EMPLOYED		
13a. U.S. AL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Montgomery			13c. CITY OR TOWN Rockville			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
13e. STREET AND NUMBER 363 Congress Road			14 FATHER'S NAME First Middle Last N.A.			15 MOTHER'S MAIDEN NAME First Middle Last N.A.					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no			16b. SOCIAL SECURITY NO 070-24-2921			17 INFORMANT MARY CEDRO (wife)			Address 263 Congress Rd		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial infarction, old and recent DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost 4109 (b) Coronary thrombosis, old and recent DUE TO, OR AS A CONSEQUENCE OF (c) Advanced coronary arteriosclerosis										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 20 hrs 20 hrs Nears	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (If either, not by medical examiner) <input type="checkbox"/>			21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory) OFF-ICE BUILDING, ETC.			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from April , 19 68 , to July 18 , 19 68 , that (I) (we) lost saw the deceased alive on July 18 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death											
22b. SIGNATURE George Sharpe M.D.						DEGREE M.D.			22c. DATE SIGNED July 18 1968		
22d. PHYSICIAN'S NAME (Type) George Sharpe, M.D.						22e. ADDRESS 10400 Conn. Ave., Kensington, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Storage			23b. DATE 7-24-1968			23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery			23d. LOCATION (City or Town) (County) (State) Suitland, Prince Georges Co.		
24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc., 5130 Wisc. Ave. N.W., Wash., D.C., 20016						25a. REC'D BY REGISTRAR JUL 23 1968			25b. REGISTRAR'S SIGNATURE Charles Judge		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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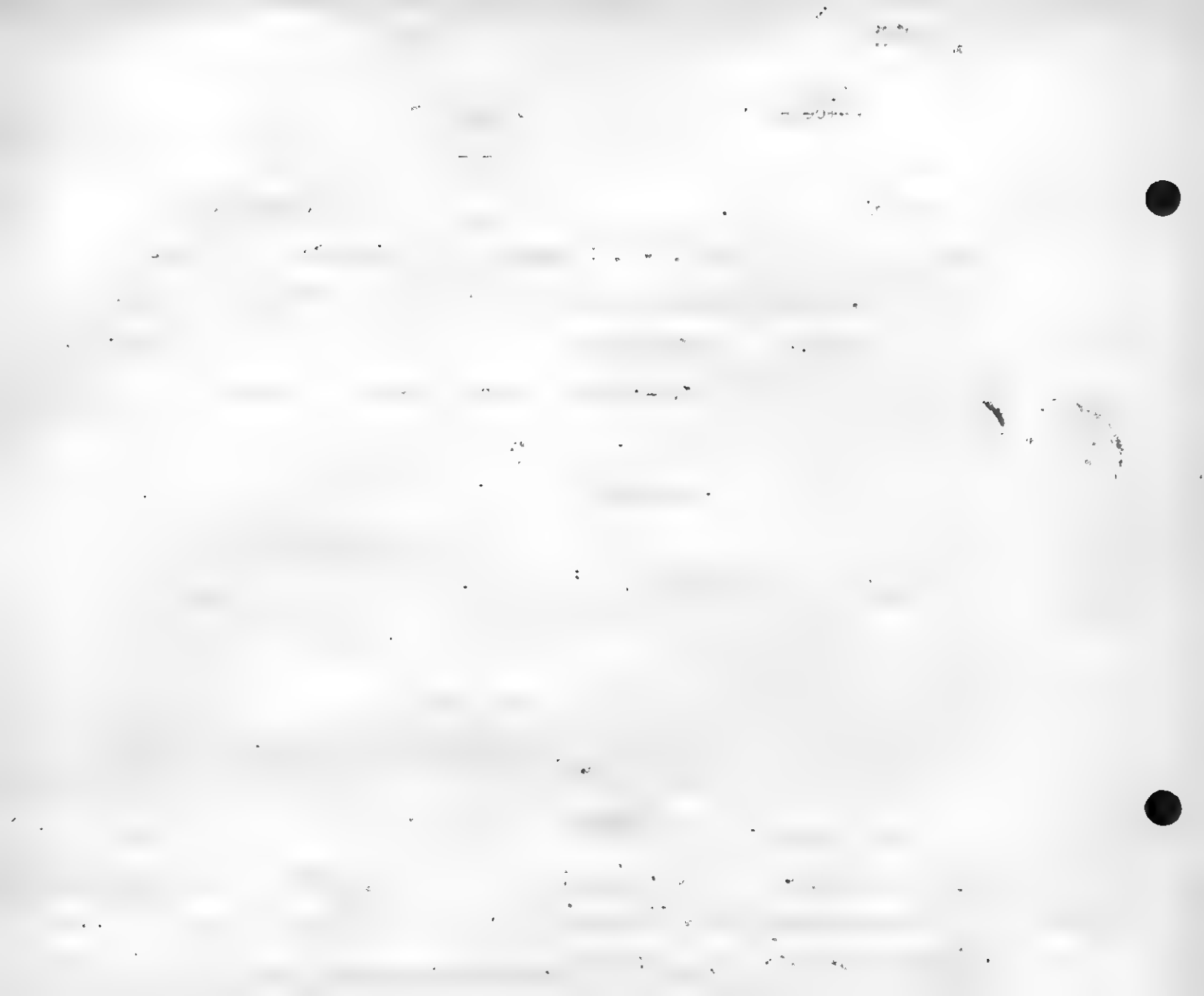
1

10156

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

10156

1. DECEASED-NAME (Type or print) Sidnor Chichester			First Middle Last Tebbs Chichester			2a. DATE OF DEATH Month 7 Day 15 Year 68			2b. HOUR M 68					
3 SEX Male			4 RACE White			5. DATE OF BIRTH 9-1-90			6 AGE (In years last birthday) 77 YRS			IF UNDER 1 YEAR MONTHS 11 DAYS 11 HOURS 11 MIN		
7a BIRTHPLACE (State or foreign country) Virginia			7b CITIZEN OF WHAT COUNTRY? Amer. USA			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH Montgomery County			Md		
10 CITY OR TOWN OF DEATH Takoma Park			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Wash. San. & Hospital			12a USUAL OCCUPATION (Kind of work done during most of work ng life, even if retired) Retired-Dept. of Justice			12b KIND OF BUSINESS OR INDUSTRY					
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.			13b COUNTY Montgomery			13c CITY OR TOWN Takoma Park			13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e STREET AND NUMBER 6913 Woodland Ave.		
14. FATHER'S NAME First Charles Middle Chichester Last Chichester			15. MOTHER'S MAIDEN NAME First ARRINGTON Middle ARRINGTON Last ARRINGTON											
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No			16b SOCIAL SECURITY NO 578-24-6520			17 INFORMANT Face sheet-Hospital Chart			Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Occlusion 11/17 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive to sclerotic Cardiovascular Disease DUE TO, OR AS A CONSEQUENCE OF (c) 3 yrs												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 hrs		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Congestive heart failure														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State								
22a. I certify that (I) (this hospital) attended the deceased from July 15, 1968 to July 15, 1968 , that (I) (we) last saw the deceased alive on July 15, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE James Whitlock			DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED July 15, 1968					
22d. PHYSICIAN'S NAME (Type) JAMES WHITLOCK			22e. ADDRESS 7717 - CARROLL AVE. TAKOMA PARK											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE July 17-1968			23c. NAME OF CEMETERY OR CREMATORY Takoma Cemetery			23d. LOCATION (City or Town) (County) (State) Takoma Park Montgomery Md.					
24. FUNERAL DIRECTOR Arthur Walters			ADDRESS 254 G Street SE. Wash. D.C.			25a. REC'D BY REGISTRAR Charles Judge			25b. REGISTRAR'S SIGNATURE Charles Judge					
DATE JUL 17 1968														



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 18 & 22a Film 404
8-26-68 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED NAME (Type or Print) First Middle Last RICHARD FRANKLIN CHRISTIAN			2a DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> Month Day Year 7-18-68		2b HOUR A.M. 8:10
3 SEX MALE	4 RACE WHITE	5 DATE OF BIRTH 11-10-66	6 AGE (In years last birthday) 1 YRS	7 IF UNDER 1 YEAR MONTHS 0 DAYS 0	8 IF UNDER 24 HRS HOURS 0 MIN 0
7a BIRTHPLACE (State or foreign country) MARYLAND		7b CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH MONTGOMERY
10 CITY OR TOWN OF DEATH GAITHERSBURG		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) RT. 1		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) NONE-CHILD	
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MARYLAND		13b COUNTY MONTGOMERY	13c CITY OR TOWN GAITHERSBURG	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e STREET AND NUMBER ROUTE 1
14. FATHER'S NAME First Middle Last OSCAR H. CHRISTIAN		15 MOTHER'S MAIDEN NAME First Middle Last ROSE MARIE GRAY			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16b SOCIAL SECURITY NO. NONE		17 INFORMANT ADDRESS MEDICAL RECORD DEPT.	
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septicemia due to Neisseria Meningitis 056.0 DUE TO, OR AS A CONSEQUENCE OF (b) and adrenal hemorrhage DUE TO, OR AS A CONSEQUENCE OF (c) (Waterhouse*Friderichsen Syndrome ?) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 057.1					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year HOUR A.M. 19 P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State		
22a I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, City, Town or County)					
ACTUAL SIGNATURE Belden R. Neap		M.D.		22b. DATE SIGNED July 18/1968	
EXAMINER'S NAME (Type) BELDEN R. NEAP M.D.					
23a BURIAL, CREMATION, REMOVAL (Specify) Burial	23b DATE 7-21-68	23c NAME OF CEMETERY OR CREMATORY Derwood Cemetery		23d LOCATION (City or Town) (County) (State) Derwood Mont. Md	
24 FUNERAL DIRECTOR Robert A Pumphrey		7557 Wisconsin Ave Bethesda, Md		25a REC'D BY REGISTRAR DATE JUL 22 1968	25b REGISTRAR'S SIGNATURE Charles Judge



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) Frances May Cissel			2a. DATE OF DEATH Month July Day 22 Year 1968		2b. HOUR M
3. SEX F	4. RACE W	5. DATE OF BIRTH Oct. 12, 1885		6. AGE (in years last birthday) 82 YRS	7. FUNERAL 1 YEAR MONTHS 1 DAYS 10
7a. BIRTHPLACE (State or foreign country) District of Columbia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> D.VORCED <input type="checkbox"/>	
9. COUNTY OF DEATH Montgomery			Md.		
10. CITY OR TOWN OF DEATH Gaithersburg		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Asbury Methodist Home		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Milliner	
12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE District of Columbia		13b. CITY OR TOWN Washington	13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 716 Crittendon St., N. E.	
14. FATHER'S NAME First Wilbur Middle Fisk Last Cissel			15. MOTHER'S MAIDEN NAME First Mary Middle Virginia Last Brown		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no		16b. SOCIAL SECURITY NO. 578-01-3508A		17. INFORMANT Address Asbury Methodist Home, Gaithersburg, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 4339 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) 10 yrs.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 mo.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, nat'l medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or RFD No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from 5/26/64 , 19____, to 7/22/68 , 19____, that (I) (we) last saw the deceased alive on 7/16/68 , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Henry C. Scruggs MD		22c. DATE SIGNED 7/22/68			
22d. PHYSICIAN'S NAME (Type) Henry C. Scruggs MD		22e. ADDRESS 5413 Cedar Lane Bethesda Md.			
23a. BURIAL, CREMATION REMOVAL (Specify) Buried		23b. DATE 7-24-68		23c. NAME OF CEMETERY OR CREMATORY Greenwood	
23d. LOCATION (City or Town) (County) (State) Washington D.C.					
24. FUNERAL DIRECTOR Ernest C. Gartner		24b. Gaithersburg, Md.		25a. REC'D BY REGISTRAR DATE JUL 24 1968	
25b. REGISTRAR'S SIGNATURE Charles J. Judd					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

10159 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or Print) First Middle Last Albert Johnson Coffman			2a. DATE KNOWN OF DEATH Month Day Year 7-31-1968			2b. HOUR PM 11:30		
3 SEX M	4 RACE White	5. DATE OF BIRTH 2-25-25	6. AGE (in years last birthday) 43 YRS	7. UNDER YEAR MONTHS DAYS 19	8. IF UNDER 24 HRS HOURS MIN 19	2c. DATE PRONOUNCED DEAD Month Day Year 7-31-1968		
7a. BIRTHPLACE (State or foreign country) Pa.		7b. CITIZEN OF WHAT COUNTRY? U. S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery		
10. CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington San & Hosp		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Machine Repairman		12b. KIND OF BUSINESS OR INDUSTRY PEPCO		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Prince George		13c. CITY OR TOWN College Park		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 9515 50th Place
14. FATHER'S NAME First Middle Last Frank Coffman			15. MOTHER'S MAIDEN NAME First Middle Last Goldie Belle Fike					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WWII-Korean			16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Wife 9515 50th Place, College Pk., Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute pneumococcal meningitis DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No City or Town County State				
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE Belden R. Reap		EXAMINER'S NAME (Type) BEIDEN R. REAP MD		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED Aug. 1, 1968		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Aug 3, 1968		23c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery		23d. LOCATION (City or Town) (County) (State) Colmar Manor Pro Geo Md.		
24. FUNERAL DIRECTOR F. Gasch's Sons				ADDRESS Hyattsville, Md.		25a. REC'D BY REGISTRAR DATE AUG 5 1968		25b. REGISTRAR'S SIGNATURE Charles Judge



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

10160

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) <i>Annie M. Coza</i>			2a. DATE OF DEATH Month <i>July</i> Day <i>27</i> Year <i>1968</i>			2b. HOUR <i>9:20 PM</i>	
3. SEX <i>Female</i>		4. RACE <i>Caucasian</i>		5. DATE OF BIRTH <i>June 23, 1893</i>		6. AGE (In years lost birthday) <i>85</i> YRS.	
7a. BIRTHPLACE (State or foreign country) <i>South Carolina</i>		7b. CITIZEN OF WHAT COUNTRY? <i>United States</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery County, Md</i>	
10. CITY OR TOWN OF DEATH <i>Wheaton, Maryland</i>		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <i>University of Maryland</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <i>Md.</i> 13b. COUNTY <i>Montgomery</i>		13c. CITY OR TOWN <i>Silver Spring</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>9501 Ocala Street</i>	
14. FATHER'S NAME First <i>Samuel</i> Middle <i>W.</i> Last <i>Wilson</i>			15. MOTHER'S MAIDEN NAME First <i>Mary Elizabeth</i> Middle <i>Green</i> Last <i>Green</i>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give year or dates of service)		16b. SOCIAL SECURITY NO <i>220-44-949</i>		17. INFORMANT <i>Betty Wallace Silver Spring, Md.</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Myocardial Infarct</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Arteriosclerotic Cardiovascular Disease</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Congestive Heart Failure</i>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Unstated</i> <i>20 years</i> <i>3 Months</i>
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Diabetes Mellitus, Anemia, Pyelonephritis</i>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I, <i>this hospital</i>) attended the deceased from <i>5/1/68</i> , 19 <i>1968</i> , to <i>7/27/68</i> , 19 <i>1968</i> , that (I) <i>was</i> lost <i>was</i> saw the deceased alive on <i>7/25/68</i> , 19 <i>1968</i> , and that in (my) <i>own</i> opinion death occurred on the date and hour and from the causes stated above, (I) <i>was</i> (did) (did not) view the body after death.							
22b. SIGNATURE <i>George B. Patrick, Jr. M.D.</i>				22c. DATE SIGNED <i>7-27-68</i>			
22d. PHYSICIAN'S NAME (Type) <i>George B. Patrick, Jr. M.D.</i>				22e. ADDRESS <i>9221 Colesville Rd., Silver Spring, Md.</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>July 31, 1968</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Rose Lawn Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Little Rock, Arkansas</i>	
24. FUNERAL DIRECTOR <i>C. Glenn Carter</i>				25a. REC'D BY REGISTRAR <i>AUG 2 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1 DECEASED NAME (Type or Print) Corinne S. Collins			2a DATE KNOWN OF DEATH Month <u>July</u> Day <u>31</u> Year <u>1968</u>			2b HOUR <u>4:45</u> A.M.			
3 SEX Female	4 RACE Cauc	5 DATE OF BIRTH Jan. 3, 1899	6 AGE (In years last birthday) 69 YRS	7 UNDER 1 YEAR MONTHS DAYS	8 UNDER 24 HRS HOURS MIN	2c DATE PRONOUNCED DEAD Month <u>July</u> Day <u>31</u> Year <u>1968</u>			2d HOUR <u>400A</u>
7a BIRTHPLACE (State or foreign country) Alabama		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.			
10. CITY OR TOWN OF DEATH Bethesda			11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Adair Hospital			12a USUAL OCCUPATION (Kind of work done during most of working life even if retired.) housewife			12b KIND OF BUSINESS OR INDUSTRY
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Virginia			13b COUNTY Arlington		13c CITY OR TOWN Arlington	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e STREET AND NUMBER 3513 Powhatan Street		
14 FATHER'S NAME Peyton Shaw			15 MOTHER'S MAIDEN NAME Katherine Rush						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no			16b SOCIAL SECURITY NO 228-30-3954A		17. INFORMANT Mr. John W. Collins, Jr., 3513 Powhatan St.				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Infarction</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Fracture of Rt Hip</u> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 Mo - 11 Weeks</u>									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>104C</u>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year <u>8:30</u> P.M. <u>May 28, 1968</u>		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) <u>Fall at home causing Fracture of Rt hip</u>					
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e PLACE OF INJURY (At home, town, street, factory, office building, etc.) <u>Home</u>		21f LOCATION Street or R.F.D. No City or Town County State <u>3513 Powhatan St Arlington Arlington Va.</u>					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <u>John S. Ball</u>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b DATE SIGNED <u>31 July 1968</u>			
EXAMINER'S NAME (Type) John G. Ball, M. D.			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
			ADDRESS (Street, city, town, or county) Arlington National Cem. Arlington, Virginia						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE Aug. 2, 1968		23c NAME OF CEMETERY OR CREMATORY Arlington National Cem.		23d LOCATION (City or Town) (County) (State) Arlington, Virginia			
24 FUNERAL DIRECTOR Arlington Funeral Home 3901 North Fairfax Drive, Arlington, Va.					25a REC'D BY REGISTRAR DATE <u>AUG 5 1968</u>		25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 12 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
10162											
10172											
1. DECEASED-NAME (Type or print) First Middle Last ELEANOR M. CONOVER						2a. DATE OF DEATH Month Day Year July 6 1968			2b. HOUR 5:15 PM		
3. SEX Female		4. RACE White		5. DATE OF BIRTH Oct. 6, 1894		6. AGE (In years last birthday) 73 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) IOWA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH MONTGOMERY Md.					
10. CITY OR TOWN OF DEATH Bethesda, Md.		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) GROVE NOR LANE NURSING HOME		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) PERSONNEL COUNSELOR FBI		12b. KIND OF BUSINESS OR INDUSTRY Govt.					
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Virginia		13b. COUNTY ✓		13c. CITY OR TOWN ALEXANDRIA		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 5606 BOUTWANT BLVD.			
14. FATHER'S NAME First Middle Last Gideon B. McFALL				15. MOTHER'S MAIDEN NAME First Middle Last FAY BALLARD							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) UNK.		16b. SOCIAL SECURITY NO		17. INFORMANT Address							
18. CAUSE OF DEATH (Enter only one cause per one for (a), (b) and (c)) PART DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4127 CIRCULATORY COLLAPSE 1-HR. DUE TO, OR AS A CONSEQUENCE OF (b) CEREBRAL VASCULAR ACCIDENTS 5+ YRS. DUE TO, OR AS A CONSEQUENCE OF (c) ARTERIO SCLEROTIC HEART DISEASE 10+ yrs. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) HYPERPYREXIA (T. 107.5°)											
19a. DATE OF OPERATION 0		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED 0		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? D.N.A.					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner) 21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21b. TIME OF INJURY HOUR A.M. Month Day Year D.N.A.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) D.N.A.							
21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.) D.N.A.		21f. LOCATION Street or R.F.D. No City or Town County State D.N.A.									
22a. I certify that (I) (this hospital) attended the deceased from 29 Sept 1963 to Present, that (I) (we) last saw the deceased alive on 7/5/68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Charles Savarose, M.D.				DEGREE M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 7/6/68			
22d. PHYSICIAN'S NAME (Type) CHARLES SAVAROSE, M.D.				22e. ADDRESS 11125 ROCKVILLE PK, ROCKVILLE, MD.							
23a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION		23b. DATE July 8, 1968		23c. NAME OF CEMETERY OR CREMATORY FORT LINCOLN		23d. LOCATION (City or Town) (County) (State) MARYLAND					
24. FUNERAL DIRECTOR Rw. Moller				ADDRESS EVERLY-WHEATLEY, ALEXANDRIA, VA.		25a. REC'D BY REGISTRAR JUL - 9 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print) First Middle Last Jay P. Conover			2a DATE OF DEATH Month 7 Day 27 Year 68		2b HOUR 7:50 A M
3 SEX Male	4 RACE Caucasian	5 DATE OF BIRTH 7-19-93		6 AGE (In years last birthday) 75 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a BIRTHPLACE (State or foreign country) NY	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.	
10 CITY OR TOWN OF DEATH Silver Spring	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Holy Cross	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE Md.	13b. COUNTY Montgomery	13c. CITY OR TOWN Silver Spring	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 3008 Dawson Ave.	
14. FATHER'S NAME First Middle Last John CONOVER.	15. MOTHER'S MAIDEN NAME First Middle Last Ella PARSONS.				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes no, or unknown yes	16b. SOCIAL SECURITY NO. WWT	17 INFORMANT Eleanor Conover		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gastric Ulcer acute - esophageal varices</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Subphragmatic abscess</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Post necrotic embolism</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH weeks - days days years.
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>December 19 67</u> to <u>July 27 19 68</u> , that (I) (we) last saw the deceased alive on <u>July 24 19 68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Hugo G. Graziani MD.</u>		DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>7/28/68</u>	
22d. PHYSICIAN'S NAME (Type) <u>HUGO G. GRAZIANI, MD.</u>		22e. ADDRESS <u>10101 Georgia Ave. Silver Spring, MD.</u>			
23a. BURIAL CREMATION, REMOVAL (Specify) <u>Cremation</u>	23b. DATE <u>7/29/68</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Lee's Crematorium</u>		23d. LOCATION (City or Town) (County) (State) <u>Washington, D. C.</u>	
24. FUNERAL DIRECTOR <u>Lee Funeral Home,</u>		ADDRESS <u>Washington, D. C.</u>		25a. REC'D BY REGISTRAR <u>DATE AUG 2 1968</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form RM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

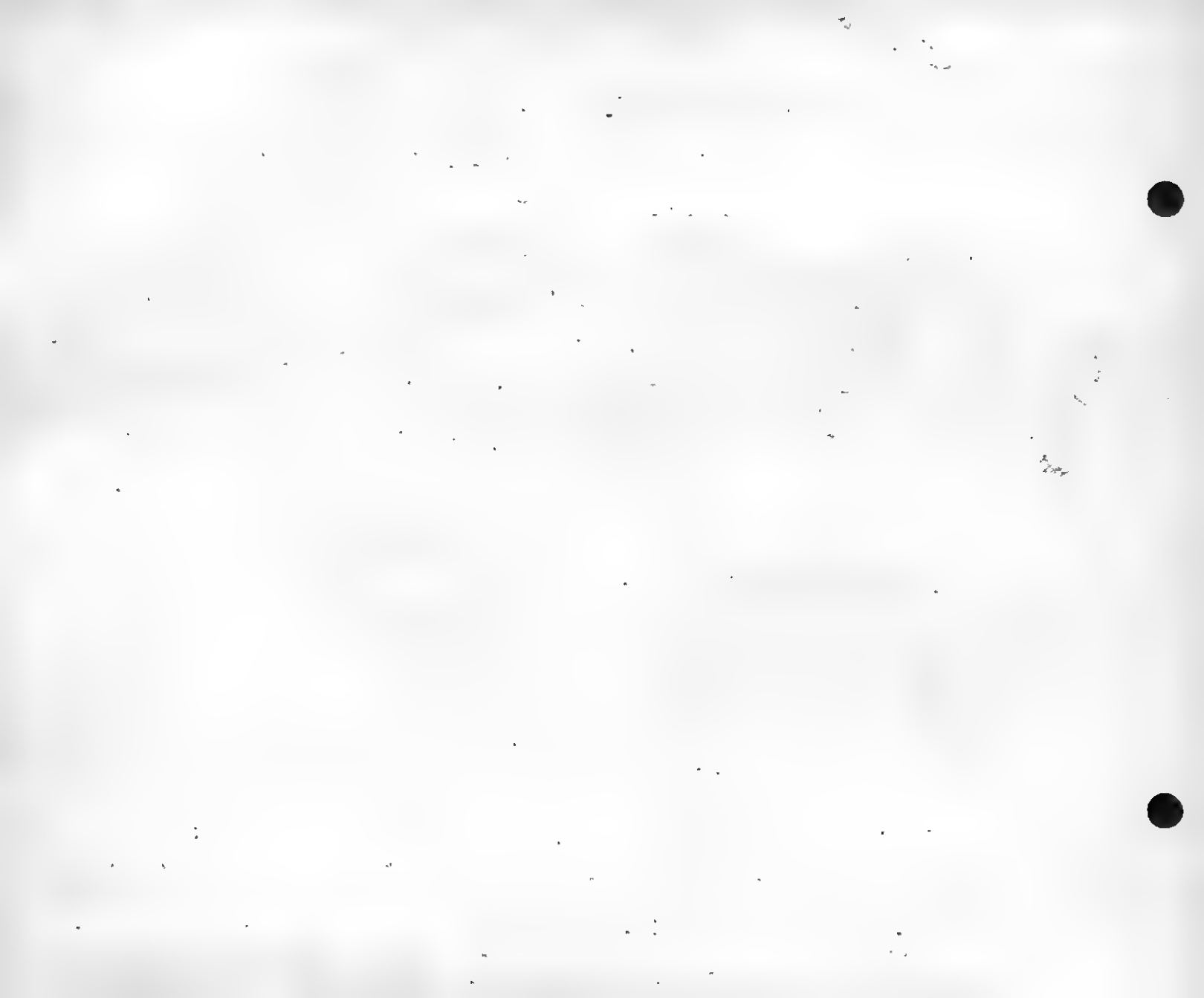
1 DECEASED-NAME (Type or Print) <i>Vera F Conrad</i>			2a DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> <i>July 4</i> 1968			2b HOUR <i>2:45</i> M		
3. SEX <i>Fe.</i>	4. RACE <i>W.</i>	5. DATE OF BIRTH <i>3/9/1915</i>	6. AGE (in years last birthday) <i>53</i> YRS	7 UNDER 1 YEAR MONTHS <i>0</i> DAYS <i>0</i>	8 UNDER 24 HRS HOURS <i>0</i> MIN <i>0</i>	2c DATE PRONOUNCED DEAD Month <i>July</i> Day <i>4</i> Year <i>1968</i>		
7a BIRTHPLACE (State or foreign country) <i>Florida</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i> Md		
10. CITY OR TOWN OF DEATH <i>Silver Spring</i>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>8107 Eastern Ave.</i>		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Data Processing</i>		12b KIND OF BUSINESS OR INDUSTRY <i>World Organization</i>		
13a USUA. RESIDENCE (Where deceased lived, if institution residence before admission) STATE <i>Md.</i>		13b COUNTY <i>Montgomery</i>		13c CITY OR TOWN <i>Silver Spring</i>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER <i>8107 Eastern Ave.</i>
14 FATHER'S NAME First <i>Sanders</i> Middle <i>Hiker</i> Last <i>Formby</i>			15 MOTHER'S MAIDEN NAME First <i>Essie</i> Middle <i>Trinnington</i> Last <i>Trinnington</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16b SOCIAL SECURITY NO <i>256-01-9857</i>		17 INFORMANT <i>Mrs. Donald H. Campbell</i>		ADDRESS <i>3737 - 36th St. Mt. Rainier, D.C.</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Anoxia</i>								
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Overdose of alcohol & equinal</i>								<i>1 hour ?</i>
DUE TO, OR AS A CONSEQUENCE OF (c) <i>last</i>								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year <i>2000 PM July 4 1968</i>		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) <i>Accidentally took too much to drink with tranquilizer - Equinal</i>				
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc) <i>Home</i>		21f LOCATION Street or R.F.D. No <i>8107 Eastern Ave.</i>		City or Town <i>Silver Spring</i>		County <i>Mont.</i> State <i>Md.</i>
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <i>John G. Ball</i>		EXAMINER'S NAME (Type) <i>John G. Ball</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b DATE SIGNED <i>5 July 68</i>		
23a BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>July 9, 1968</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Arlington National Cem.</i>		23d. LOCATION (City or Town) <i>Arlington</i>		(County) <i>Virginia</i> (State)
24. FUNERAL DIRECTOR <i>John G. Ball</i>				25a REC'D BY REGISTRAR <i>JUL 11 1968</i>		25b REGISTRAR'S SIGNATURE <i>John G. Ball</i>		

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="display: flex; justify-content: space-between;"> <div> <div style="border: 1px solid black; padding: 2px; margin-bottom: 5px;">10169</div> <div>Item #</div> </div> <div> <div style="border: 1px solid black; padding: 2px; margin-bottom: 5px;">Item 230</div> <div>File #</div> </div> <div> <div style="border: 1px solid black; padding: 2px; margin-bottom: 5px;">10169</div> <div>File #</div> </div> </div> <div style="text-align: center; margin-top: 5px;"> <div style="border: 1px solid black; padding: 2px; display: inline-block;">DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> </div>											
CERTIFICATE OF DEATH											
1. DECEASED NAME (Type or print)				First Middle Last				2a. DATE OF DEATH			2b. HOUR AT
Linda				Gayle Cox				July 22 1968			1:10 M
3. SEX		4. RACE		5. DATE OF BIRTH				6. AGE (In years last birthday)		7. IF UNDER 1 YEAR	
Female		White		April 4, 1961				7 YRS.		MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country)				7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Virginia				USA				Montgomery Md.			
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
Bethesda				The Clinical Center, NIH				Child		--	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
Virginia				King George		King George		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Route 2, Box 544	
14. FATHER'S NAME First Middle Last				15. MOTHER'S MAIDEN NAME First Middle Last							
Thomas E. Cox				Audrey M. Loving							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16b. SOCIAL SECURITY NO.		17. INFORMANT Address					
No				None		The Medical Record The Clinical Center, Bethesda, Maryland					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Lymphocytic Leukemia										4 years	
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
DUE TO, OR AS A CONSEQUENCE OF											
(b) _____											
(c) _____											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
Right upper lobe pneumonia											
19a. DATE OF OPERATION		19b. CONDIT ON FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> or work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)				21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (A) (this hospital) attended the deceased from June 10, 1968, to July 22, 1968, that (A) (we) last saw the deceased alive on July 22, 1968, and that in (my) (our) apinion death occurred on the dote and hour and from the causes stated above, (A) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Harmon J. Eyre M.D.								22c. DATE SIGNED 22 July 1968			
22d. PHYSICIAN'S NAME (Type) Harmon J. Eyre, M.D.						22e. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE July 24, 1968		23c. NAME OF CEMETERY OR CREMATORY Mountague		23d. LOCATION (City or Town) (County) (State) Kings George - Kings George, Va					
24. FUNERAL DIRECTOR Nash & Shaw Funeral Address						25a. REC'D BY REGISTRAR DATE JUL 26 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH											
1 DECEASED NAME (Type or print) <i>Concettina P. Cozzo</i>						2a DATE OF DEATH Month <i>7</i> Day <i>27</i> Year <i>68</i>		2b HOUR <i>3:20 PM</i>			
3. SEX <i>Female</i>		4 RACE <i>White</i>		5 DATE OF BIRTH <i>Dec. 8, 1900</i>		6 AGE (In years last birthday) <i>67</i> YRS		F UNDER 1 YEAR MONTHS		IF UNDER 24 HRS HOURS M.N.	
7a. BIRTHPLACE (State or foreign country) <i>Italy</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <i>Montgomery</i> Md.					
10. CITY OR TOWN OF DEATH <i>Kensington</i>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Nursing Home Kensington Gardens</i>		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>					
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <i>Md.</i>		13b. COUNTY <i>Prince Geo. Hyattsville</i>		13c. CITY OR TOWN <i>Hyattsville</i>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>1516 Chillum Road</i>			
14. FATHER'S NAME First <i>Carmelo</i> Middle <i>Puglisi</i> Last <i>Grazia</i>				15 MOTHER'S MAIDEN NAME First <i>Deluca</i> Middle <i>Deluca</i> Last <i>Deluca</i>							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>no</i>		16b SOCIAL SECURITY NO <i>578-44-0602</i>		17 INFORMANT <i>Mrs. Mary De Filippo</i>		6702 Addressed Avenue Hyattsville, Md.					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cirrhosis of the Liver.</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Chronic Biliary Disease</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>5/11/9</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>5710</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>6 months</i> <i>10 yrs.</i>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Diabetes mellitus</i>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, not by medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <i>March</i> , 19 <i>48</i> to <i>July 26</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>July 26</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Bertram F. Schaefer, M.D.</i>				22c. DATE SIGNED <i>July 27, 1968</i>		22d. PHYSICIAN'S NAME (Type) <i>Bertram F. Schaefer, M.D.</i>		22e. ADDRESS <i>1780 Mass. Ave. N.W. Wash. D.C.</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <i>July 31, 1968</i>		23c. NAME OF CEMETERY OR CREMATORY <i>St. Lincoln Mausoleum</i>		23d. LOCATION (City or Town) (County) (State) <i>Prince Georges Co., Md.</i>					
24. FUNERAL DIRECTOR <i>Warner C. Humphrey, Inc.</i>		24b. ADDRESS <i>8434 Georgia Ave. Silver Spring, Md.</i>		25a. REC'D BY REGISTRAR <i>AUG 2 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Dr. J. Paul notified and approved (signed)

10167										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										10177																			
1. DECEASED-NAME (Type or print)										2a. DATE OF DEATH										2b. HOUR																			
First Middle Last Mary C. Crivella										Month Day Year July 1 1968										H.P. M																			
3. SEX Female										4. RACE Caucasian										5. DATE OF BIRTH 2-12-1951										6. AGE (In years last birthday) 17 YRS.									
7a. BIRTHPLACE (State or foreign country) Wash., D.C.										7b. CITIZEN OF WHAT COUNTRY? U.S.A.										8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										9. COUNTY OF DEATH Montgomery Md.									
10. CITY OR TOWN OF DEATH Chevy Chase										11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) 8109 Kerry Rd.										12a. USUAL OCCUPATION (Kind of work done during most of work ng life, even if retired) Student										12b. KIND OF BUSINESS OR INDUSTRY									
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland										13b. CITY OR TOWN Montgomery										13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>										13e. STREET AND NUMBER 8109 Kerry Rd.									
14. FATHER'S NAME First Middle Last Barto J. Crivella										15. MOTHER'S MAIDEN NAME First Middle Last Elizabeth Donghia																													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give year or dates of service) NO										16b. SOCIAL SECURITY NO 220-46-6673										17. INFORMANT Address Mrs. Barto J. Crivella, Mother, see item 1																			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Terminale Carcinoma</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Multiple Metastases</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Osteogenic Sarcoma of Bone</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 mo.</u> <u>6 mo.</u> <u>1 yr.</u>																													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)																																							
19a. DATE OF OPERATION Aug 19 1967										19b. CONDIT ON FOR WHICH OPERATION WAS PERFORMED LEFT LEG OSTEOGENIC SARCOMA										20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? N.A.									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>										21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19										21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) N.A.																			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING ETC. (we) N.A.										21f. LOCATION Street or R.F.D. No. City or Town County State N.A.																			
22a. I certify that (I) (this hospital) attended the deceased from <u>JUNE 4, 1968</u> to <u>JULY 1, 1968</u> , that (I) (we) saw the deceased alive on <u>JUNE 30, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																																							
22b. SIGNATURE Edward S. Witowski, Jr. M.D.										DEGREE M.D.										ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>										22c. DATE SIGNED July 3, 1968									
22d. PHYSICIAN'S NAME (Type) EDWARD S WITOWSKI, JR. M.D.										22e. ADDRESS SUITE 400, 8218 WISCONSIN AVE. BETHESDA MARYLAND 20817.																													
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial										23b. DATE 7-6-1968										23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery										23d. LOCATION (City or Town) (County) (State) Bladensburg, Prince Georges									
24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc., Wash., D.C.										ADDRESS 5130 Wisc. Ave.										25a. REC'D BY REGISTRAR JUL - 9 1968										25b. REGISTRAR'S SIGNATURE Co., Md. Charles Judge									

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR 115 (M)
30M REV 11-68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
CERTIFICATE OF DEATH												
1 DECEASED NAME (Type or print) <i>David Blaine Cunningham</i>						2a. DATE OF DEATH Month <i>July</i> Day <i>29</i> Year <i>1968</i>			2b. HOUR <i>10 A M</i>			
3 SEX <i>Male</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>2/8/65</i>		6 AGE (In years last birthday) <i>3</i> YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		
7a BIRTHPLACE (State or foreign country) <i>Wash. D.C.</i>		7b CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <i>Mont. Co.</i> Md.						
10 CITY OR TOWN OF DEATH <i>Silver Spring</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Holy Cross Hospital</i>				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>None</i>			12b KIND OF BUSINESS OR INDUSTRY <i>None</i>			
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <i>Md.</i>				13b. COUNTY <i>P.G.</i>		13c CITY OR TOWN <i>Greenbelt</i>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER <i>5921 Cherrywood Terrace</i>		
14. FATHER'S NAME First <i>David</i> Middle <i>B.</i> Last <i>Cunningham</i>				15. MOTHER'S MAIDEN NAME First <i>Lesley</i> Middle <i>J.</i> Last <i>Anderson</i>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <i>No</i> (If yes give war or dates of service)				16b. SOCIAL SECURITY NO. <i>None</i>		17 INFORMANT <i>David B. Cunningham</i> Address <i>5921 Cherrywood Terrace Greenbelt, Md.</i>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Embryonal Rhabdomyosarcoma</i> <i>1710</i> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 months</i>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>None</i>												
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, natlly medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)								
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State		
22a. I certify that (I) (this hospital) attended the deceased from <i>July 26</i> , 19 <i>68</i> , to <i>July 29</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>July 29</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b SIGNATURE <i>Frank W. Neuberger</i>						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>July 29, 1968</i>				
22d. PHYSICIAN'S NAME (Type) <i>FRANK W NEUBERGER</i>						22e. ADDRESS <i>8708 FIRST AVE, SILVER SPRING</i>						
23a BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>		23b. DATE <i>July 30, 1968</i>		23c. NAME OF CEMETERY OR CREMATORY <i>St. Lincoln Crematory</i>		23d LOCATION (City or Town)		(County)		(State)		
24 FUNERAL DIRECTOR <i>Warner E. Pumphrey, Inc.</i>		ADDRESS <i>8434 Georgia Ave. Silver Spring, Md.</i>		25a REC'D BY REGISTRAR <i>AUG 2 1968</i>		25b REGISTRAR'S SIGNATURE <i>Charles Judge</i>						



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers - Pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VA 15-1 (4)
30M REV. 1-68

10169

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

10179

1. DECEASED-NAME (Type or print) Isabel First Currier Middle Last			2a. DATE OF DEATH Month July Day 1 Year 1968			2b. HOUR M			
3 SEX Female		4 RACE White		5. DATE OF BIRTH Dec. 10, 1882		6 AGE (In years last birthday) 85 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) None		7b. CITIZEN OF WHAT COUNTRY? U.S.A		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md			
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 515 Philadelphia Ave Takoma Park Md		12a. USUAL OCCUPATION (If past of work done during most of working life, even if retired) Housewife		12b. KIND OF BUSINESS OR INDUSTRY At Home			
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE M.D. COUNTY Montgomery		13b. CITY OR TOWN Brockton		13c. STATE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 83 Bellview Ave			
14. FATHER'S NAME First Eker Middle Clough Last Clough			15. MOTHER'S MAIDEN NAME First Louise Middle R Last Mumler						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No (If yes give year or dates of service)		16b. SOCIAL SECURITY NO. 013-09-0801		17. INFORMANT Mrs. Louise R. Mumler Address 515 Philadelphia Ave Takoma Park Md					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Malabsorption Syndrome									19 wks
DUE TO, OR AS A CONSEQUENCE OF (b) Carcinoma of bowel									1 yr +
DUE TO, OR AS A CONSEQUENCE OF (c) 1 yr +									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Anemia - Senility Arteriosclerosis									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from Feb 25, 1968 to July 1, 1968 , that (I) (we) last saw the deceased alive on June 28, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Philip E. Jones M.D.				22c. PHYSICIAN'S NAME (Type) Philip E. Jones MD		22d. ADDRESS 800 Pershing Drive Silver Spring, Md		22e. DATE SIGNED July 1, 1968	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE July 3, 1968		23c. NAME OF CEMETERY OR CREMATORY Melrose Cemetery		23d. LOCATION (City or town) (County) (State) Brockton Massachusetts			
24. FUNERAL DIRECTOR W. W. Chambers Co.				25a. REC'D BY REGISTRAR JUL - 5 1968		25b. REGISTRAR'S SIGNATURE J. Charles Judge			



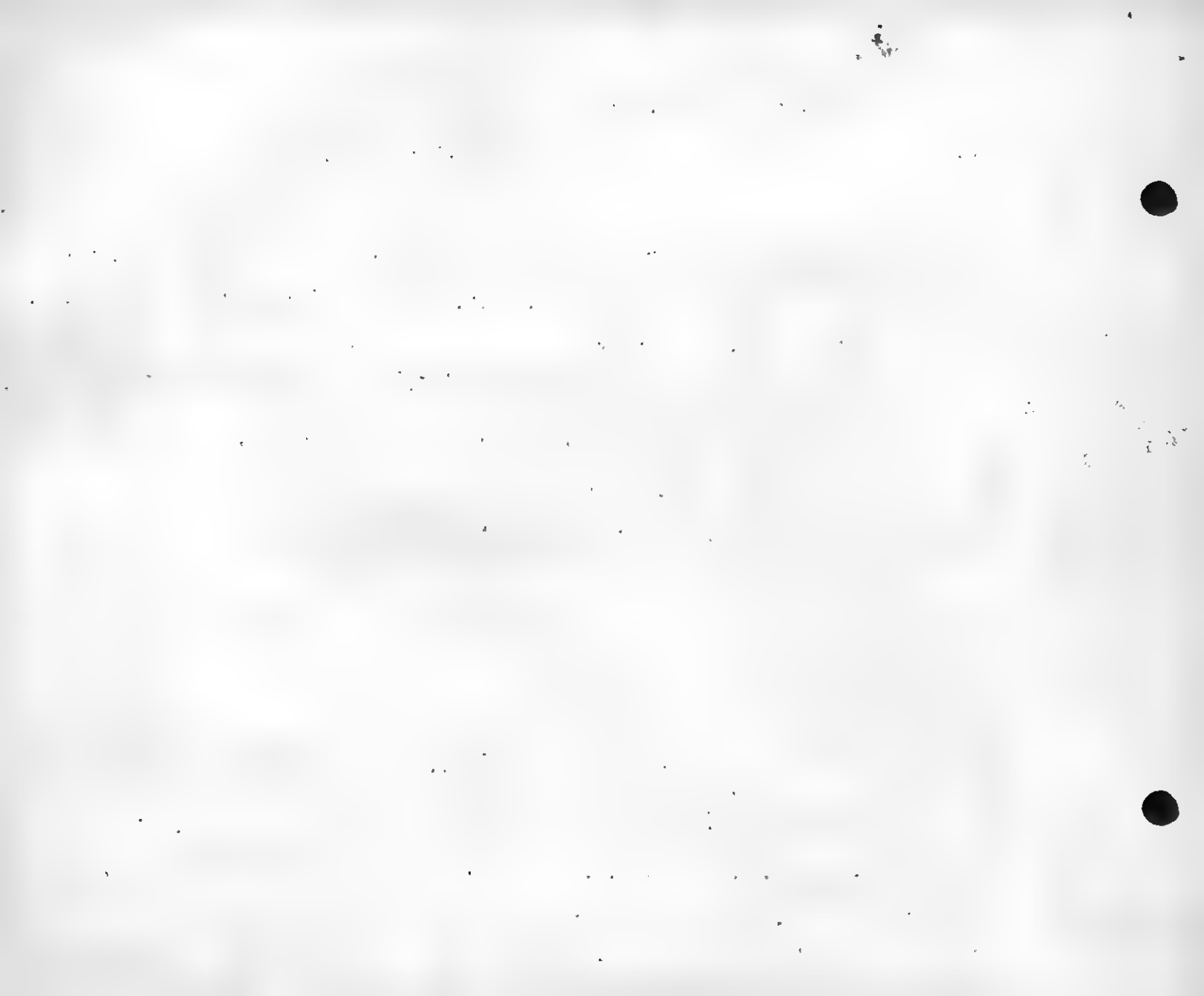
CERTIFICATE OF DEATH

10130

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

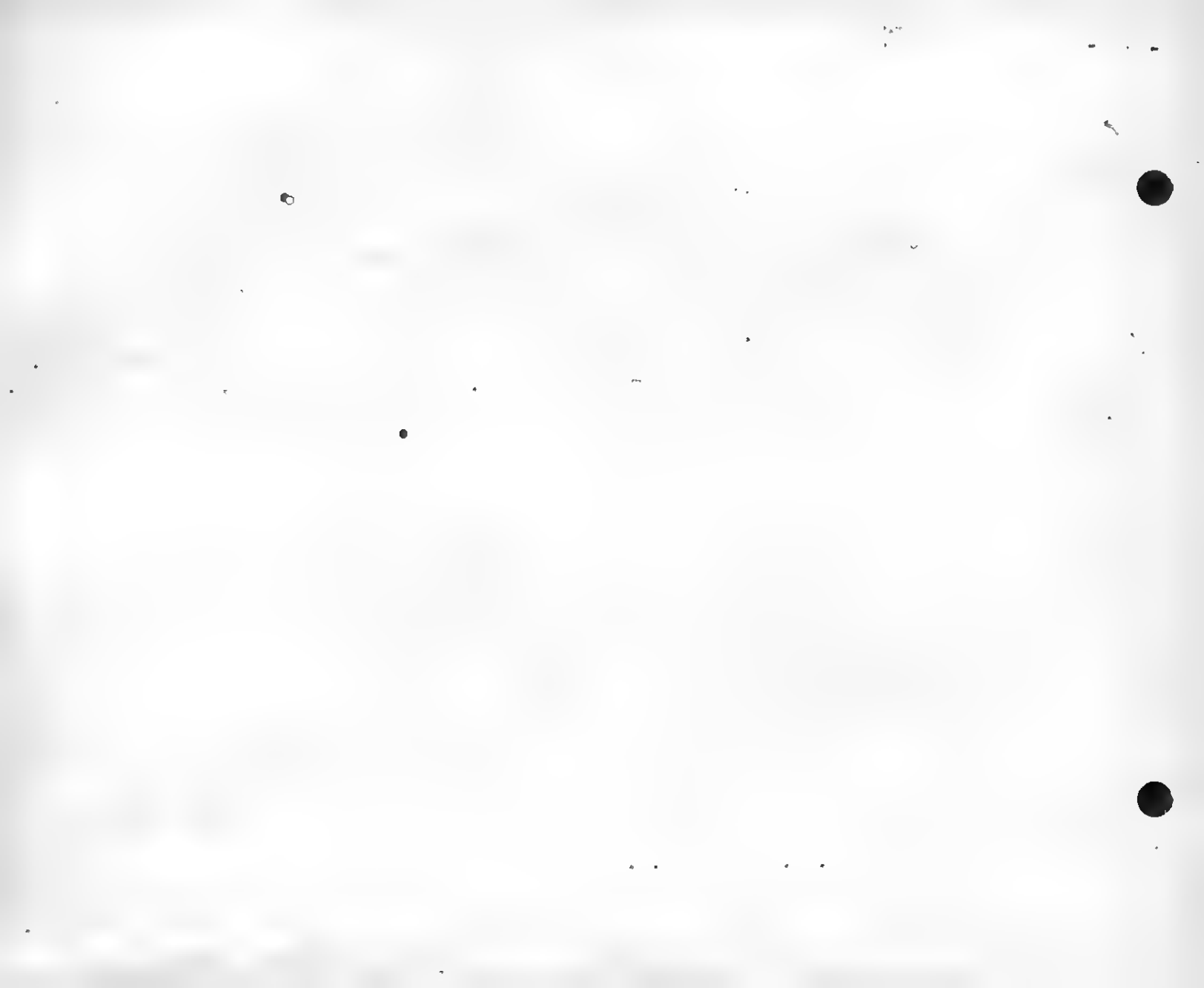
1 DECEASED NAME (Type or print) Phyllis Genevieve Curry			2a. DATE OF DEATH Month Day Year July 15 1968			2b. HOUR A.M. OR P.M. 11:05 AM			
3 SEX Female		4 RACE White		5 DATE OF BIRTH September 7, 1909		6 AGE (In years last birthday) 58 YRS		7 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a BIRTHPLACE (State or foreign country) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery County, Md.			
10. CITY OR TOWN OF DEATH Bethesda		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) The Clinical Center, NIH		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Clerk		12b. KIND OF BUSINESS OR INDUSTRY U.S. Govt.			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE D.C.		13b. COUNTY Wash., D.C.		13c. CITY OR TOWN Wash., D.C.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 2430 Pennsylvania Ave., N.W.	
14. FATHER'S NAME First Middle Last Harold F. Curry			15. MOTHER'S MAIDEN NAME First Middle Last May Reed						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16b. SOCIAL SECURITY NO. 577-60-0178		17 INFORMANT The Medical Record, Clinical Center, National Institutes of Health, Bethesda, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intestinal Obstruction due to metastases</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Radiation Enteritis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Adenocarcinoma of the urethra</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 months 2 years 3 years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>11/11</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED Where <input type="checkbox"/> Not while at work <input type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING ETC.		21f. LOCATION Street or R.F.D. No		City or Town		County State	
22a. I certify that <u>X</u> (this hospital) attended the deceased from <u>Nov. 20</u> , 19 <u>67</u> , to <u>July 15</u> , 19 <u>68</u> , that <u>X</u> (we) last saw the deceased alive on <u>July 15</u> , 19 <u>68</u> , and that in <u>X</u> (our) opinion death occurred on the date and hour and from the causes stated above <u>X</u> (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Samuel B. Itscoitz, M.D.</u>				DEGREE M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 15 July 1968	
22d. PHYSICIAN'S NAME (Type) Samuel B. Itscoitz, M.D.				22e. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md. 20014					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE Burial 7-16-1968		23c. NAME OF CEMETERY OR CREMATORY St. Leo's Catholic		23d. LOCATION (City or Town) (County) (State) Ridgeway, Penna.			
24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc., 5130 Wisc. Ave. N.W., Wash., D.C., 20016				25a. REC'D BY REGISTRAR DATE JUL 17 1968		25b. REGISTRAR'S SIGNATURE <u>Charles J. J...</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 48 hours after death.

MARTIN LUTHER KING, JR. DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
1. DECEASED-NAME (Type or print)		First Mary	Middle Jane	Last DAILEY	2a. DATE OF DEATH JULY Day 12 Year 68			2b. HOUR 6:00 P.M.	
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH 18 APRIL 1923 v		6. AGE (In years last birthday) 45 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS	
7a. BIRTHPLACE (State or foreign country) NEW YORK		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.			
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Naval Hospital		12a. USUA. OCCUPATION (Kind of work done during most of working life, even if retired) Secretary		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased admission) STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Kensington		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 11103 Jolly Way	
14. FATHER'S NAME Thomas		First	Middle F.	Last McNamara	15. MOTHER'S MAIDEN NAME Anna Walsh		First	Middle	Last Walsh
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> or unknown		16b. SOCIAL SECURITY NO. 217-12-5863		17. INFORMANT MRS. William GREANERY, 1826 Brisbane Ct.		Address Silver Spng.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer of Uterus (Leiomyosarcoma Uterus)</u> 18d. DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 14 X									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County	State
22a. I certify that (I) (this hospital) attended the deceased from <u>19 OCT</u> , 19 <u>67</u> , to <u>12 JULY</u> , 19 <u>68</u> that (I) (we) last saw the deceased alive on <u>12 JULY</u> , 19 <u>68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (d) (do) view the body after death.									
22b. SIGNATURE <u>R. L. Gibbs</u>		22c. PHYSICIAN'S NAME (Type) R. L. GIBBS M.D.		22d. ADDRESS U. S. NAVAL HOSP.		22e. DATE SIGNED 12 JULY 68		22f. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 7/17/68		23c. NAME OF CEMETERY OR CREMATORY Arlington National Cem		23d. LOCATION (City or Town) Arl.		(County)	(State) Va.
24. FUNERAL DIRECTOR Robert A. Pumphrey 7557 Wisc. Ave. Beth		24a. ADDRESS		24b. DATE JUL 16 1968		24c. REGISTRAR'S SIGNATURE			



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

101722

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10182

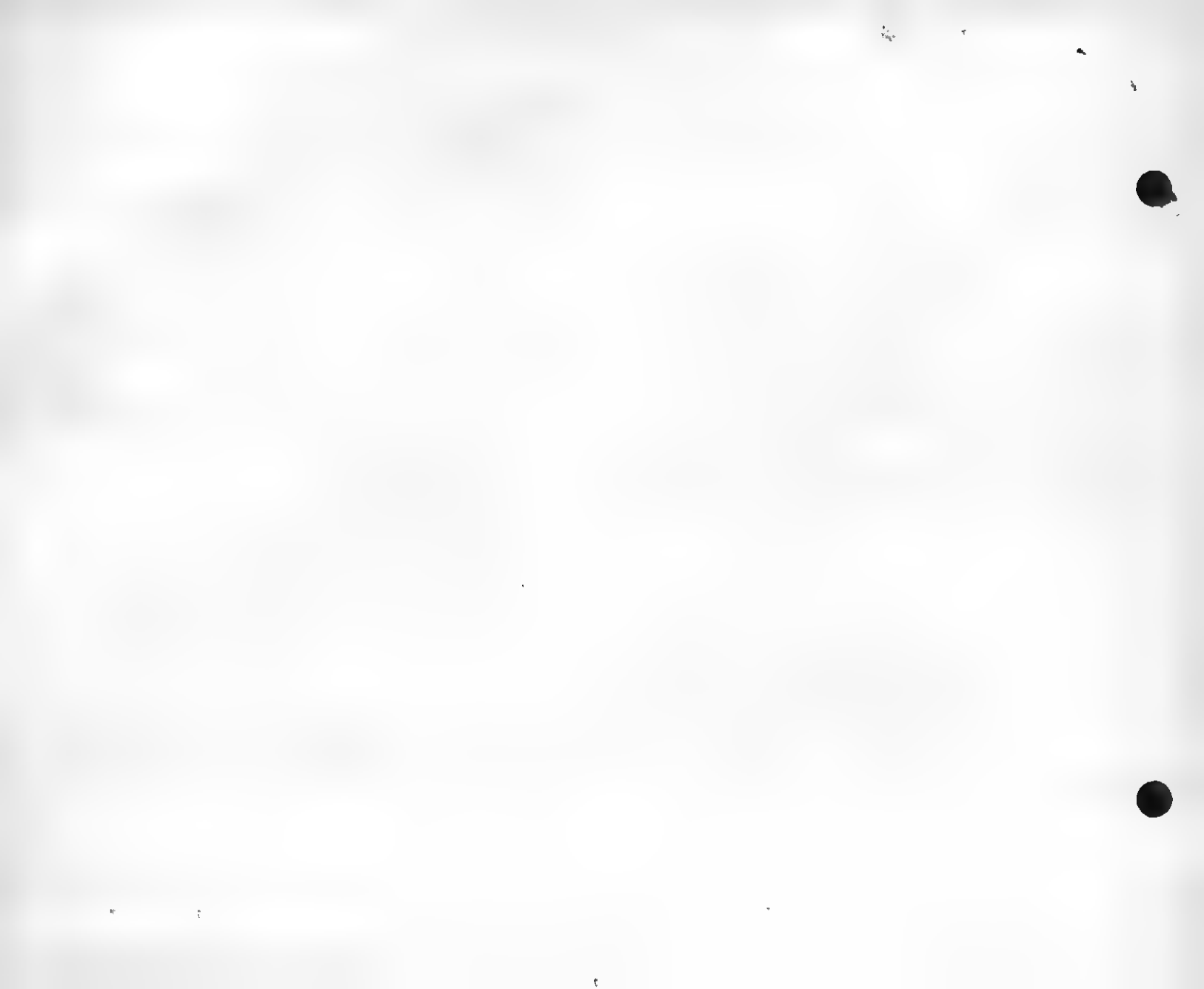
1 DECEASED NAME (Type or Print) <i>Frank K. Adam, Jr.</i>			2a DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> <i>July 10</i> 19 <i>68</i> 7 <i>43</i> AM		
3 SEX <i>Male</i>	4 RACE <i>White</i>	5. DATE OF BIRTH <i>10/3/23</i>	6 AGE (In years last birthday) <i>44</i> YRS	IF UNDER 1 YEAR MONTHS _____ DAYS _____	IF UNDER 24 HRS HOURS _____ MIN _____
7a BIRTHPLACE (State or foreign country) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10 CITY OR TOWN OF DEATH <i>Bethesda</i>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban Accounting Clerk</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Old Co.</i>	
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>MD</i>		13b COUNTY <i>Fairfax</i>		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME <i>Frank - Davis</i>		15 MOTHER'S MAIDEN NAME <i>Doris - E. Rison</i>		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>Yes - World War II</i>	
16b SOCIAL SECURITY NO <i>219-12-3499</i>		17 INFORMANT <i>Glen Dale, Md. Lois Kozlowski, Glen Dale Hosp.</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Injuries, multiple, severe</i> DUE TO, OR AS A CONSEQUENCE OF <i>to auto accident</i> (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Sudden</i>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>1234</i>					
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b TIME OF INJURY Month, Day, Year <i>7:10 P.M. 7/10 1968</i>		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) <i>Run off Road - Hit over Pass aboutment</i>	
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <i>Highway</i>		21f LOCATION Street or R.F.D. No _____ City or Town _____ County _____ State _____ <i>Beltway 475 on Rison Road - Bethesda - Montgomery Md</i>		
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>John G. Ball</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b DATE SIGNED <i>July 11, 1968</i>	
EXAMINER'S NAME (Type) <i>John G. Ball</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		ADDRESS (Street, city, town, or county) <i>Marbury, Charles, Md.</i>			
23a BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b DATE <i>July 13, 1968</i>	23c NAME OF CEMETERY OR CREMATORY <i>Park Hill Cemetery</i>		23d LOCATION (City or Town) (County) (State) <i>Marbury, Charles, Md.</i>	
24 FUNERAL DIRECTOR <i>Arehart Funeral Home Inc., La Plata, Md</i>		ADDRESS		25a. REC'D BY REGISTRAR <i>JUL 16 1968</i>	25b REGISTRAR'S SIGNATURE <i>Charles Judge</i>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1 DECEASED-NAME (Type or print) First Middle Last Donald Ayres Dehashmuth						2a. DATE OF DEATH Month Day Year July 10 1968			2b. HOUR 1:30 P M		
3 SEX M		4. RACE W		5. DATE OF BIRTH 12-24-85		6. AGE (In years last birthday) 82 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.					
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Potomac Valley Nursing Home				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Lawyer			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RES. DENCE (Where deceased lived, if institution. Residence before admission) STATE Md.		13b. COUNTY Montgomery		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 110 Upton St.			
14. FATHER'S NAME First Middle Last Elias Dehashmuth		15. MOTHER'S MAIDEN NAME First Middle Last Susan Ramsburgh									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b. SOCIAL SECURITY NO		17. INFORMANT Frances Renshaw - Daughter				Address Rockville Md			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Congestive Heart Failure DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) Arteriosclerotic Cardiovascular Disease DUE TO, OR AS A CONSEQUENCE OF (c) 15 years										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 25 days	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Diabetes mellitus											
19a. DATE OF OPERATION None		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTR. BUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from March 1968 to July 10, 1968 , that (I) (we) last saw the deceased alive on July 9 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Stephen C. Cromwell MD						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 7-10-68			
22d. PHYSICIAN'S NAME (Type) Stephen C. Cromwell, MD						22e. ADDRESS 615 W Montgomery Ave, Rockville, Md					
23a. BURIAL, CREMATION, REINTERMENT Burial		23b. DATE 7-13-68		23c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery		23d. LOCATION (City or Town) Rockville, Mont.		(County)		(State)	
24. FUNERAL DIRECTOR Robert A Pumphrey						ADDRESS 7557 Wisconsin Ave Bethesda, Md		25a. REC'D BY REGISTRAR JUL 15 1968		25b. REGISTRAR'S SIGNATURE J Charles Judge	



Delegated to Registrar
Cleared with medical examiner
TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
It #1, 7107103 7/21/68 km										
CERTIFICATE OF DEATH										
1. DECEASED NAME (Type or print) First Middle Last NELLIE S. DENNISON					2a. DATE OF DEATH 7 Month 22 Day 68 Year			2b. HOUR 9:40 M		
3 SEX FE		4 RACE White		5 DATE OF BIRTH 6-28-83		6 AGE (in years last birthday) 85 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN		
7a. BIRTHPLACE (State or foreign country) PENNSYLVANIA		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH MONTGOMERY Md.				
10 CITY OR TOWN OF DEATH CHEVY CHASE			11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) BETHESDA SUMMER SPRING NCH HOME			12a. USUAL OCCUPATION (Kind of work done during most of work life, even if retired) HOUSE		12b. KIND OF BUSINESS OR INDUSTRY NURSING.		
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE MD			13b. COUNTY MONTGOMERY		13c. CITY OR TOWN ROCKVILLE		13d. INS OF CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 12100 BAILWOOD DR.	
14 FATHER'S NAME First Middle Last WILLIAM SMITH			15 MOTHER'S MAIDEN NAME First Middle Last ELISA MCCORMICK							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO. 267-36-2916		17 INFORMANT ALBERT HURIMAC		Address 12100 BAILWOOD DR. ROCKVILLE, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Anterosclerotic Heart Disease DO TO, OR AS A CONSEQUENCE OF Generalized Anterosclerosis (b) DO TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 4200 Fracture of hip										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> at home <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 1965, to present, that (I) (we) last saw the deceased alive on 27 June 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE IRA N. TUBLIN M.D.					DEGREE M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 22 July 1968	
22d. PHYSICIAN'S NAME (Type) IRA N. TUBLIN					22e. ADDRESS 800 PERSHING DR. SILVER SPRING, MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 7/26/68		23c. NAME OF CEMETERY OR CREMATORY Rockwood		23d. LOCATION (City or Town) (County) (State) FALLS Creek Jefferson Pa.				
24 FUNERAL DIRECTOR TYSON WHELER					25a. REC'D BY REGISTRAR DATE JUL 24 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 18-22a Film 403 MARYLAND STATE DEPARTMENT OF HEALTH
7-31-68 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10175

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED NAME (Type or Print)		First BARBARA		Middle JEAN		Last DICKSON		2a. DATE KNOWN OF DEATH ESTIMATED <input type="checkbox"/> <input checked="" type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year <input type="checkbox"/> 19 <input type="checkbox"/>		2b. HOUR M <input type="checkbox"/>	
3 SEX Female		4 RACE White		5 DATE OF BIRTH		6 AGE (in years last birthday) 32 YRS		IF UNDER 1 YEAR MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>		F UNDER 24 HRS HOURS <input type="checkbox"/> MIN <input type="checkbox"/>	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH MONTGOMERY		2c. DATE PROMULGATED DEAD Month 7 Day 17 , Year 1968		2d. HOUR 4:30 PM	
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Academy Way		2a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) STATE Md.		13b. COUNTY Montgomery		13c. CITY OR TOWN Rockville		3d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 12202 Braxfield Court		Apt. 14	
14. FATHER'S NAME First Middle Last		15. MOTHER'S M.A.D.E.N. NAME First Middle Last									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO (If yes give war or dates of service)		17. INFORMANT		ADDRESS					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Overdose of meprobamate</u> 950.2 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION 9702		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day Year HOUR A M ? P M 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) Took overdose of meprobamate							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Car in parking lot		21f. LOCATION Street or R.F.D. No Academy Way		City or Town Rockville		County Montg		State Md.	
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Charles S. Springate		EXAMINER'S NAME (Type) Charles S. Springate, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED July 18, 1968	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 7-26-68		23c. NAME OF CEMETERY OR CREMATORY V. of Md. Med. School		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.					
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR DATE JUL 30 1968		25b. REGISTRAR'S SIGNATURE <i>John Carlos Jones</i>					



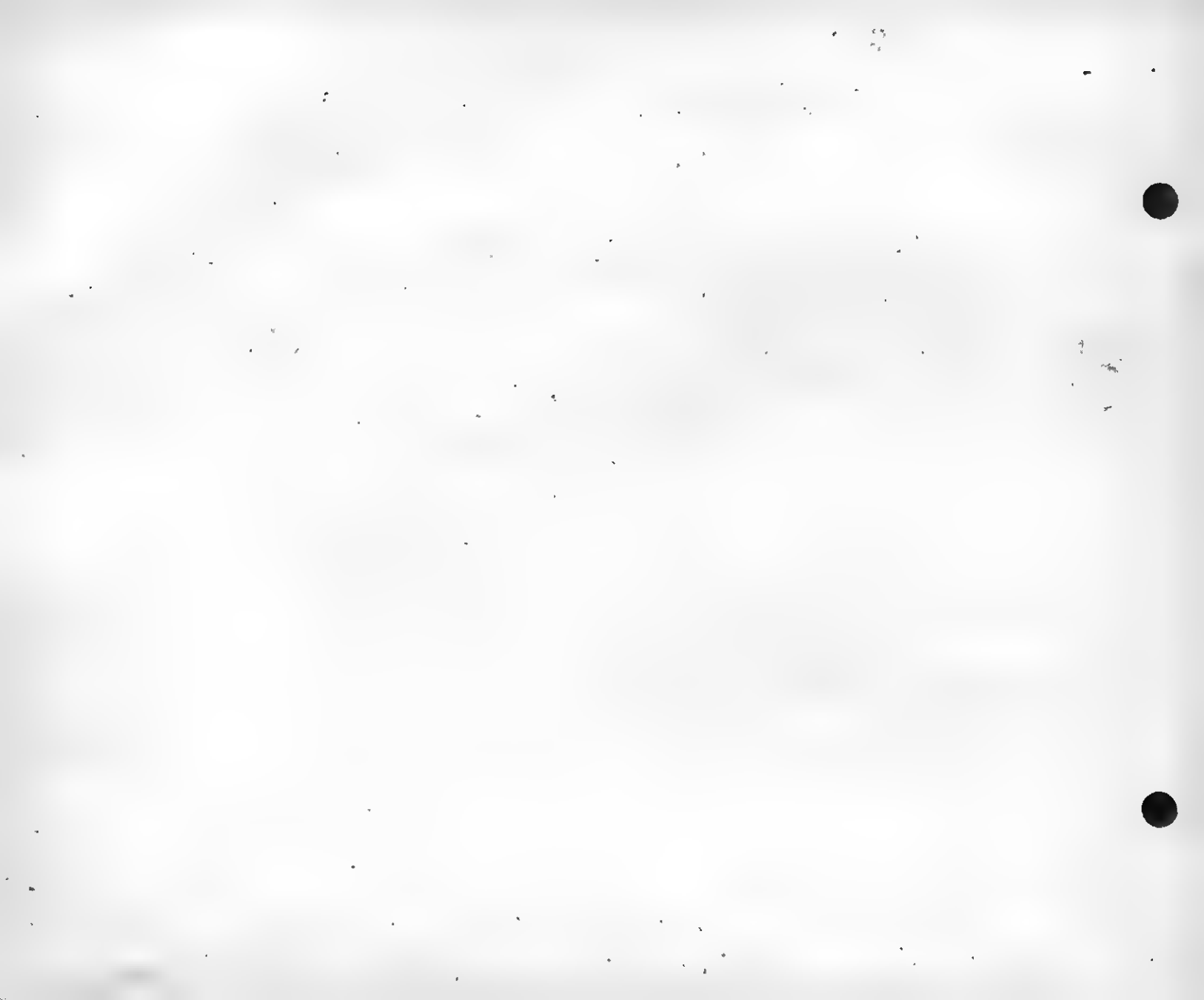
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it is completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print) <i>The First Middle Last</i> <i>ELGIN DOANE</i>			2a. DATE OF DEATH Month <i>July</i> Day <i>28</i> Year <i>1968</i>			2b. HOUR <i>2:40</i> <i>PM</i>	
3. SEX <i>MALE</i>		4. RACE <i>white</i>		5. DATE OF BIRTH <i>11-30-1913</i>		6. AGE (In years last birthday) <i>54</i> YRS	
7a. BIRTHPLACE (State or foreign country) <i>Virginia</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i> Mo.	
10. CITY OR TOWN OF DEATH <i>BETHESDA</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>GLASS CUTTER</i>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE <i>MARYLAND</i>		13b. COUNTY <i>Montgomery</i>		13c. CITY OR TOWN <i>Rockville</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER <i>13801 Bauer Drive</i>		14. FATHER'S NAME First Middle Last <i>HARRY S. DOANE</i>		15. MOTHER'S MAIDEN NAME First Middle Last <i>NANNIE GREER</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>NO</i>		16b. SOCIAL SECURITY NO <i>130 03 5023</i>		17. INFORMANT <i>Daughter - Virginia Als</i>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Acute Myocardial Infarction Secondary to</i> DUE TO, OR AS A CONSEQUENCE OF <i>Arteriosclerosis</i> (b) <i>Arteriosclerosis</i> DUE TO, OR AS A CONSEQUENCE OF <i>Diabetes Mellitus</i> (c) <i>Diabetes Mellitus</i>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <i>3220</i>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <i>27 July, 1968</i> , to <i>27 July, 1968</i> , that (I) (we) last saw the deceased alive on <i>27 July, 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>James J. Daum</i>		DEGREE <i>MD</i>		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <i>28 July 1968</i>	
22d. PHYSICIAN'S NAME (Type) <i>James J. Daum</i>		22e. ADDRESS <i>4777 Butler Lane Bethesda</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		23b. DATE <i>AUG 1, 1968</i>		23c. NAME OF CEMETERY OR CREMATORY <i>DERWOOD CEMETERY</i>		23d. LOCATION (City or Town) (County) (State) <i>DERWOOD MARYLAND</i>	
24. FUNERAL DIRECTOR <i>W. W. Chamberlain Inc</i>		ADDRESS <i>Silver Spring, Md</i>		25a. REC'D BY REGISTRAR <i>John J. Judge</i>		25b. REGISTRAR'S SIGNATURE <i>John J. Judge</i>	
DATE <i>AUG 14 1968</i>							



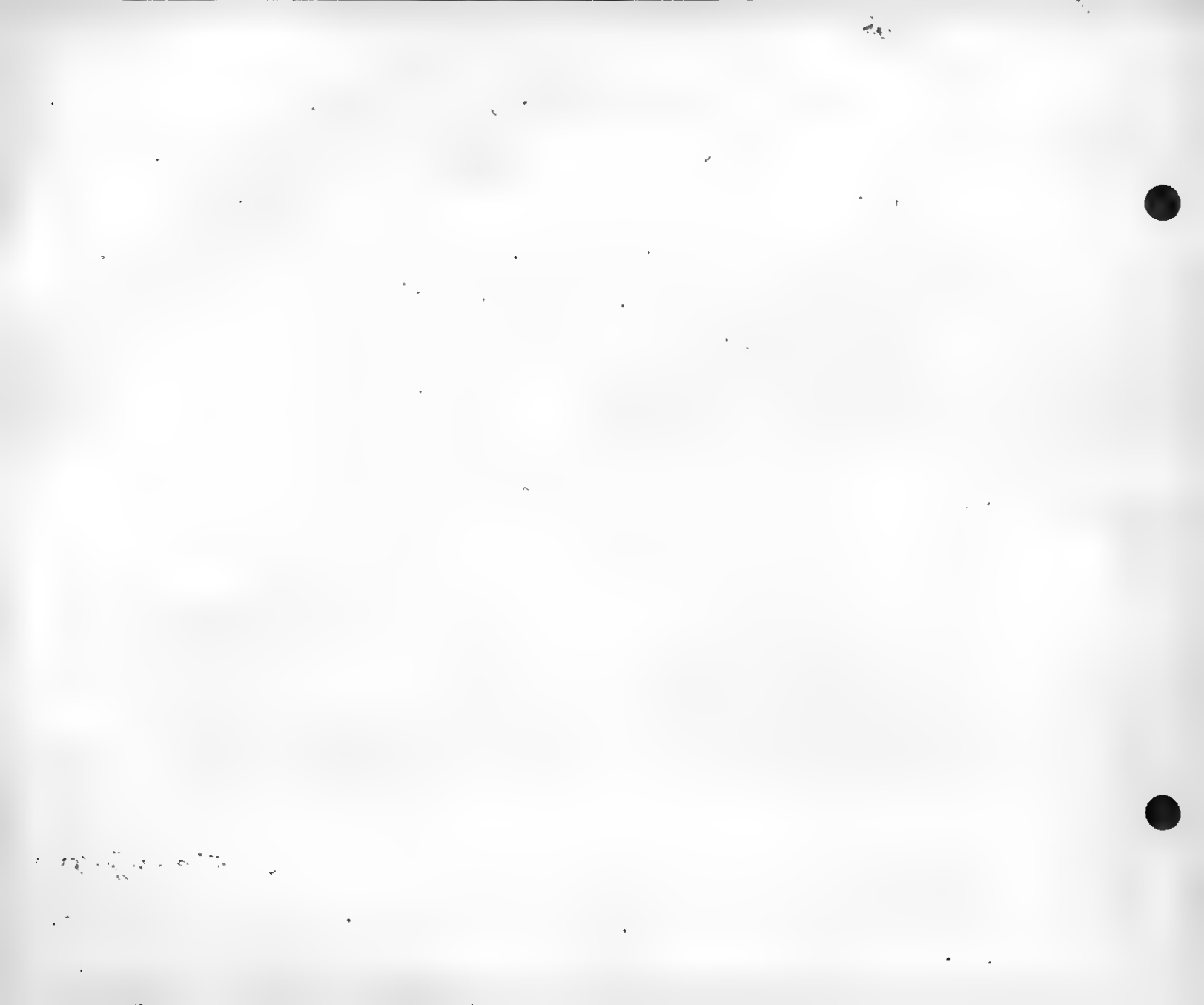
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10177

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 only 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print) First Middle Last Metzie Marie Downey			2a. DATE OF DEATH Month Day Year July 12, 1968		2b. HOUR 9:35 M
3 SEX Female	4. RACE White	5. DATE OF BIRTH July 11, 1968		6 AGE (In years last birthday) YRS. 0 MONTHS 1 DAYS	IF UNDER 1 YEAR MONTHS DAYS 0 1
7a. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Montgomery Md		
10. CITY OR TOWN OF DEATH Takoma Park	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington San. & Hosp		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) None	12b KIND OF BUSINESS OR INDUSTRY None	
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.	13b COUNTRY Prince Geo.	13c CITY OR TOWN Brentwood	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET AND NUMBER 3809 Windom Road	
14. FATHER'S NAME First Middle Last Edward Franklin Downey	15 MOTHER'S MAIDEN NAME First Middle Last Edith May Rothwell		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		
16b. SOCIAL SECURITY NO None		17 INFORMANT Baby's chart			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cardiac & respiratory arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Premature baby 1 lb 7 oz. DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 110 -					
19a. DATE OF OPERATION None	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State		
22a. I certify that (I) (this hospital) attended the deceased from July 11, 1968 to July 12, 1968 , that (I) (we) last saw the deceased alive on July 12, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE John D. Ruffcorn		DEGREE MD.	ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED 7. 31. 68	
22d. PHYSICIAN'S NAME (Type) John D. Ruffcorn		22e. ADDRESS			
23a. BURIAL, CREMATION, OR OTHER DISPOSAL (Specify) Cremation	23b. DATE 7-25-68	23c. NAME OF CEMETERY OR CREMATORY Wash. San & Hospital	23d. LOCATION (City or Town) (County) (State) Takoma Park, Mont., Md.		
24. FUNERAL DIRECTOR John D. Ruffcorn, 7600 Carroll Ave,			25a. REC'D BY REGISTRAR AUG 5 1968		25b. REGISTRAR'S SIGNATURE J. Charles Judge
26. ADDRESS Takoma Park, Maryland					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301-W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1 DECEASED NAME (Type or print)			First Middle Last			2a DATE OF DEATH Month Day Year		2b HOUR P.		
Esther Pauline Duwall						July 8, 1968		4:15 M		
3 SEX		4 RACE		5. DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		
female		white		Aug. 10, 1903		64 YRS.				
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Maryland		U. S.				Montgomery Md				
10. CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY		
Rockville			717 Grandin Ave.			housewife		at home		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER	
Maryland			Montgomery		Rockville		YES		1311 Grandin Ave.	
14 FATHER'S NAME First Middle Last			15 MOTHER'S MAIDEN NAME First Middle Last							
Charles Moore			Emma Barnes							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)			16b SOCIAL SECURITY NO.		17. INFORMANT Address					
no			no		219-14-9172 Phyllis D. Kavanagh, Rockville, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Congestive heart failure 4 years										
CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Aortic Aortic stenosis 20 years										
DUE TO, OR AS A CONSEQUENCE OF (c)										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Generalized arteriosclerosis										
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M.		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (did not) attend the deceased from 1/25/1967 to 7/8/1968, that (I) (did not) saw the deceased alive on 7/8/1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (did) (did not) view the body after death.										
22b. SIGNATURE			22c. DATE SIGNED							
Robert C. Macon			July 8, 1968							
22d. PHYSICIAN'S NAME (Type)			22e ADDRESS							
Robert C. Macon, M.D.			809 Viers Mill Rd. Rockville, Md.							
23a BURIAL, CREMATION, REMOVAL		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Burial		July 11, 1968		Kriders Cemetery		Westminster, Carroll, Md				
24. FUNERAL DIRECTOR ADDRESS			25a REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
New Windsor, Md.			DATE JUL 12 1968		Charles Judge					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV 1/68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1 DECEASED-NAME (Type or print)			First	Middle	Last	2a DATE OF DEATH			2b HOUR
MABEL OLIVIA DYER						Month	Day	Year	9:25 AM
3 SEX	4 RACE		5. DATE OF BIRTH			6. AGE (In years lost birthday)		IF UNDER 1 YEAR	IF UNDER 24 HRS
FEMALE	CAUC		7-21-10			57 YRS		MONTHS	DAYS
7a BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Maryland		Amer				Montgomery Md			
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY	
Takoma Park			Washington San + Hosp			Hsult		Own Home	
13a. USUAL RESIDENCE (Where deceased lived, if institution before admission) STATE			13b. COUNTY		13c CITY OR TOWN	13d. INSIDE CITY LIMITS?		13e STREET AND NUMBER	
Md			Montgomery		Wheaton	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		11504 Amherst Ave.	
14 FATHER'S NAME			First	Middle	Last	15 MOTHER'S MAIDEN NAME			
HARRY C. TAYLOR						Lottie Allen			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO			17 INFORMATION		Address	
No			yes			George E. Dyer		11504 Amherst Avenue Wheaton, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
HEPATIC FAILURE									DAYS
LAENNET'S CIRRHOSIS									YRS.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
ESOPHAGEAL VARICES WITH BLEEDING									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
		HOUR A.M. Month Day Year P.M. 19							
21d. INJURY OCCURRED While <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a I certify that (I) (this hospital) attended the deceased from SEPT. 1966, to JULY 16, 1968, that (I) (we) lost the deceased alive on JULY 16, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death									
22b SIGNATURE		22c. DATE SIGNED				22d. PHYSICIAN'S NAME (Type)			
Albert H. Grollman MD		7/17/68				ALBERT H. GROLLMAN MD			
		22e ADDRESS				22f. REGISTRAR'S SIGNATURE			
		1106 GRIFFIN ST. SILVER SPRING				JUL 23 1968			
23a BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		July 19, 1968		St. John's Cemetery		Forest Glen, Maryland			
24 FUNERAL DIRECTOR		24a ADDRESS		24b. REC'D BY REGISTRAR		24c. REGISTRAR'S SIGNATURE			
Warner E. Humphrey, Inc.		8434 Georgia Ave. Silver Spring, Md.		JUL 23 1968		Charles Judge			



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Item PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or Print) <u>XXXXXX Marilyn Joyce Eger</u>		2a DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <u>7</u> Day <u>17</u> Year <u>1968</u>		2b HOUR <u>9:30</u> M
3 SEX <u>Female</u>	4 RACE <u>White</u>	5 DATE OF BIRTH <u>April 25, 1932</u>	6 AGE (In years last birthday) <u>36</u>	7c DATE PRONOUNCED DEAD Month <u>7</u> Day <u>17</u> Year <u>1968</u>
7a BIRTHPLACE (State or foreign country) <u>Evansville, Ind. U. S. A.</u>		7b CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH <u>Montgomery</u>
10. CITY OR TOWN OF DEATH <u>Takoma Pk.</u>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Washington San & Hosp.</u>	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <u>Nurse</u>	12b KIND OF BUSINESS OR INDUSTRY <u>Private Duty</u>
13a USUAL RESIDENCE (Where deceased admission) STATE <u>Maryland</u>	13b COUNTY <u>Montgomery</u>	13c CITY OR TOWN <u>Silver Sp.</u>	13d INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13e STREET AND NUMBER <u>9318 Walden Rd.</u>
14. FATHER'S NAME First <u>George</u> Middle <u>Schnepfer</u> Last <u></u>		15 MOTHER'S MAIDEN NAME First <u>Thelma</u> Middle <u>Brendsasse</u> Last <u></u>		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16b SOCIAL SECURITY NO <u>yes</u>		17 INFORMANT <u>Leo J. Eger</u> ADDRESS <u>9318 Walden Rd. Silver Spring, Md.</u>
18 CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute cardiorespiratory failure,</u> DUE TO, OR AS A CONSEQUENCE OF <u>Etiology undetermined</u> (b) <u></u> DUE TO, OR AS A CONSEQUENCE OF <u></u> (c) <u></u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)				
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED?		20 AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b TIME OF INJURY Month, Day, Year <u>19</u>		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No <u></u> City or Town <u></u> County <u></u> State <u></u>
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>				
ACTUAL SIGNATURE <u>Belden R. Reap</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
EXAMINER'S NAME (Type) <u>BELDEN R. REAP, M.D.</u>		ADDRESS <u>4434 Georgia Ave. Silver Spring, Md.</u>		
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b DATE <u>July 22, 1968</u>	23c NAME OF CEMETERY OR CREMATORY <u>St. Josephs Cemetery</u>	23d LOCATION (City or Town) <u>Evansville, Ind.</u>	(County) <u></u> (State) <u></u>
24 FUNERAL DIRECTOR <u>Warner E. Pumphrey, Inc.</u>		25a REC'D BY REGISTRAR <u>JUL 24 1968</u>		25b REGISTRAR'S SIGNATURE <u>Charles J...</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

10181

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

9i

1. DECEASED NAME (Type or print) <u>Annie M. Ellis</u>			2a. DATE OF DEATH Month <u>July</u> Day <u>23</u> Year <u>1968</u>			2b. HOUR <u>10:45</u> AM	
3. SEX <u>Female</u>		4. RACE <u>White</u>		5. DATE OF BIRTH <u>March 23 1895</u>		6. AGE (In years last birthday) <u>73</u> YRS.	
7a. BIRTHPLACE (State or foreign country) <u>Washington D.C.</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <u>Montgomery</u> Mo	
10. CITY OR TOWN OF DEATH <u>U. Leaton</u>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Randolph Hills Nursing Home</u>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <u>Press feeder for a Printing Office</u>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <u>Maryland</u>		13b. COUNTY <u>Montgomery</u>		13c. CITY OR TOWN <u>Silver Spring</u>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER <u>10003 Forest Grove Drive</u>		14. FATHER'S NAME First <u>John</u> Middle <u>Demetrius</u> Last <u>Myers</u>		15. MOTHER'S MAIDEN NAME First <u>Anna</u> Middle <u>O'Brien</u> Last <u>O'Brien</u>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <u>no</u>		16b. U.S. ARMY SERVICE NO. <u>4003</u>		17. INFORMANT <u>James W. Ellis</u>		17a. ADDRESS <u>4003 London Terrace Rockville, Maryland</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Chronic Arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Chronic Aortic Atherosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs</u> <u>4 mos</u> <u>4 yrs</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>15</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <u>19</u>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>July 19, 1968</u> to <u>July 23, 1968</u> , that (I) (we) last saw the deceased alive on <u>July 22, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (and not) view the body after death.							
22b. SIGNATURE <u>John P. Haberlin</u>				22c. DATE SIGNED <u>7-23-68</u>			
22d. PHYSICIAN'S NAME (Type) <u>John P. Haberlin</u>				22e. ADDRESS <u>9801 GEORGIA AVE SILVER SPRING</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>July 27, 1968</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. John's Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Forest Glen, Maryland</u>	
24. FUNERAL DIRECTOR <u>Warner E. Humphrey, Inc.</u>				24a. ADDRESS <u>8434 Georgia Avenue Silver Spring, Md.</u>		25a. REC'D BY REGISTRAR <u>JUL 29 1968</u>	
				25b. REGISTRAR'S SIGNATURE <u>John Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
<div>10182</div> <div>Items 1 & 14 Film # G402 7/25/68 vmi</div> <div>CERTIFICATE OF DEATH</div>									
1. DECEASED-NAME (Type or print)			First Middle Last			2. DATE OF DEATH			2b. HOUR
Henry Conrad Englebrack						Month 7 Day 11 Year 68			11 15 AM
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS	
male		white		5-4-90		18 YRS			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		12b. KIND OF BUSINESS OR IND. STRY	
Pa.		Amer.				Montgomery County		U.S. Gov't	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)					
TAKOMA PARK		WASH. SAN. + HOSPITAL		Pressman Retired					
13a. USUAL RESIDENCE (Where deceased lived if institution - Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Fla.		-----		Dunellon		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		BOX 49	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
Conrad Englebrack			Dorothy McCalfe						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or Unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address				
yes			WWI 263-76-5245		Mrs. Grace Horan Wheaton				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Vascular Accident									7 wks
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									
(b) Hypertension + Coronary Heart Disease - 2 yrs									
(c) Atherosclerosis									years
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
4x01									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from May 27, 1968, to July 11, 1968, that (I) (we) lost the deceased alive on July 11, 1968, and that (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Philip E. Jones M.D. DEGREE				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 7/12/68			
22d. PHYSICIAN'S NAME (Type) Philip E. Jones MD				22e. ADDRESS 800 Pershing Drive Silver Spring, Md					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County) (State)	
Burial		July 15, 1968		Arlington National Cem.		Arlington		Virginia	
24. FUNERAL DIRECTOR		24b. ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
John W. Leath, Jr.		8434 Ga. Ave. S.E., Md		JUL 17 1968		Charles Judge			

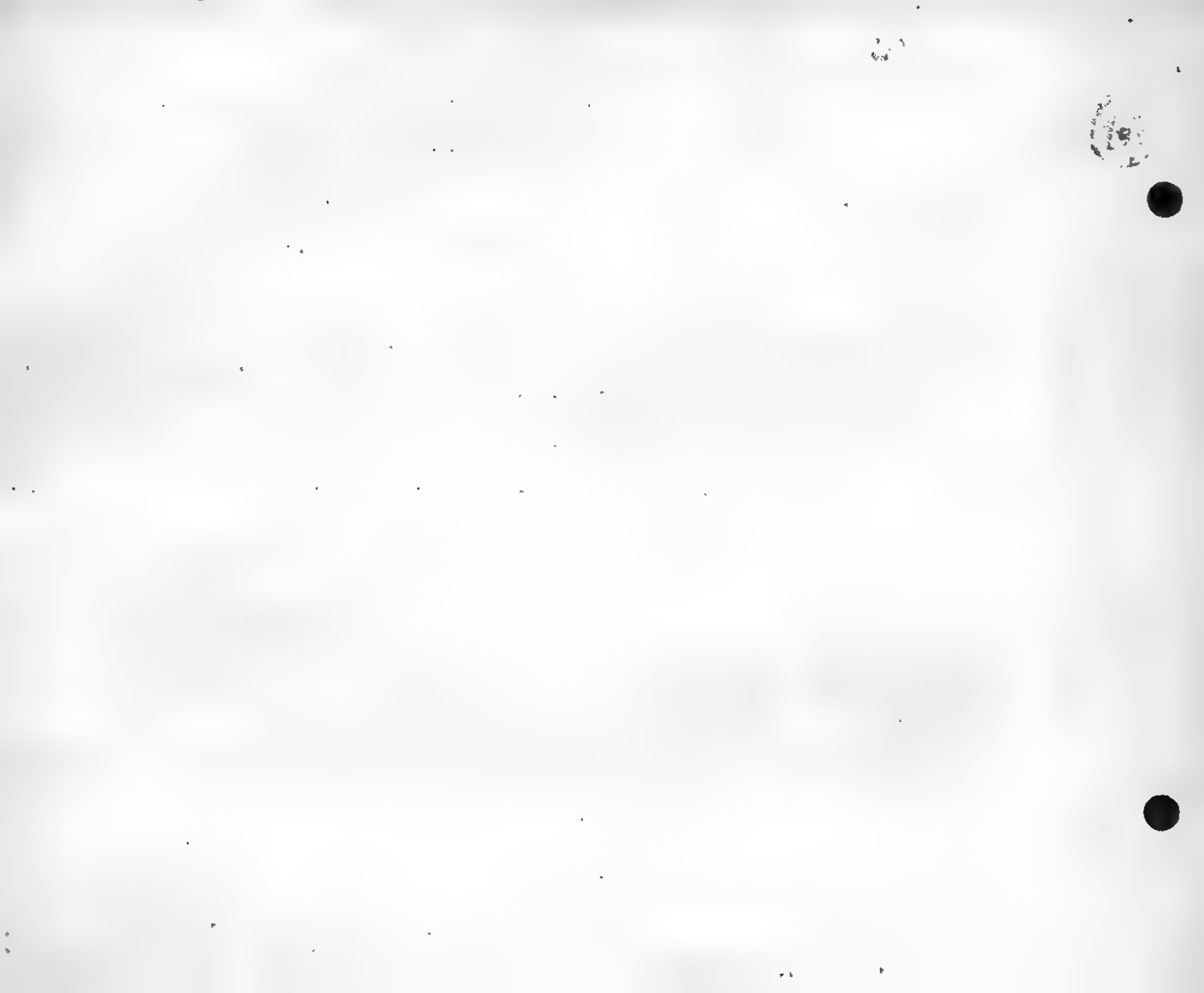


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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

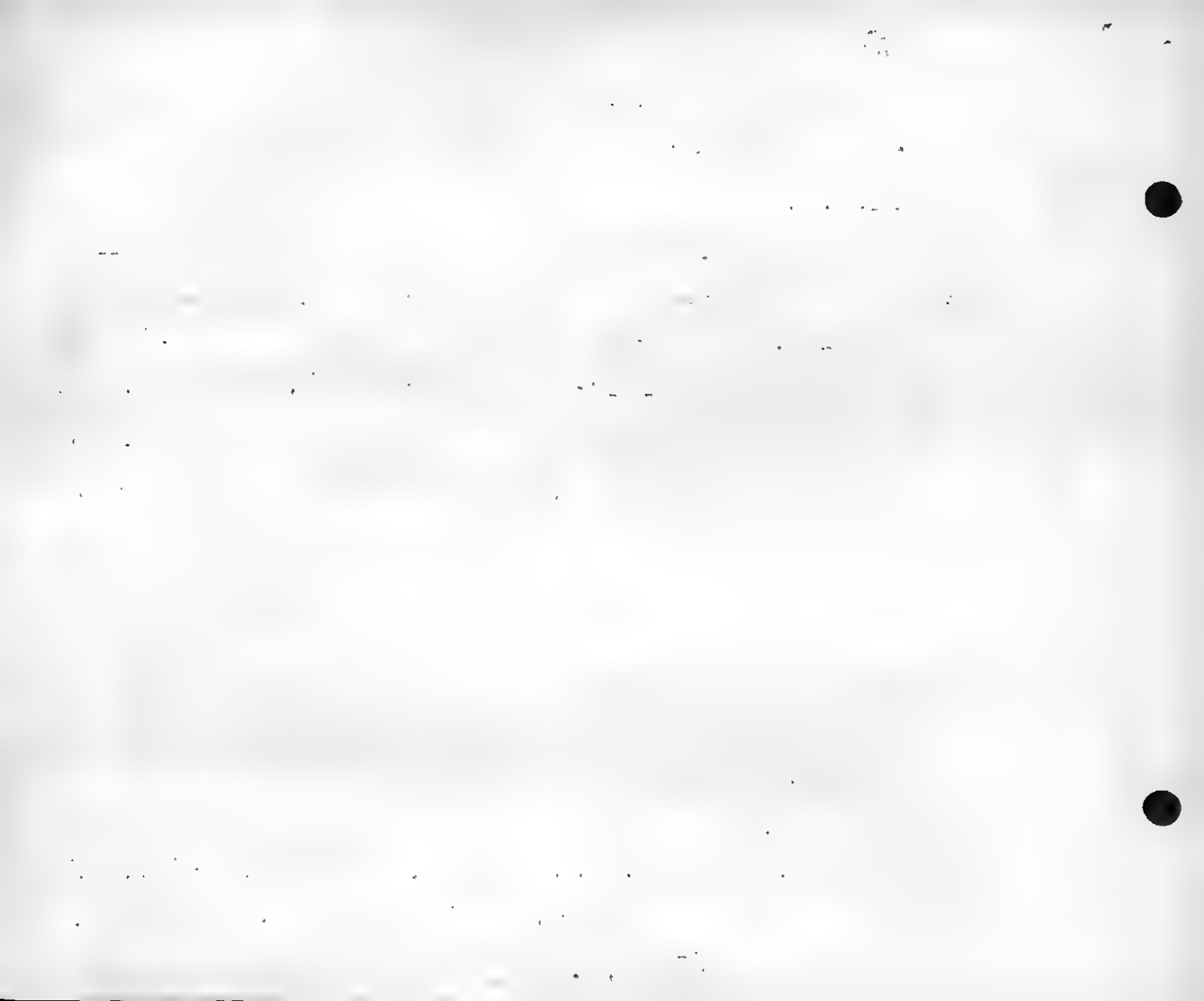
1. DECEASED-NAME (Type or print) Hanna Anderson Ewing			2a. DATE OF DEATH Month 7 Day 13 Year 1968			2b. HOUR 4 P.M.			
3. SEX Female		4. RACE White		5. DATE OF BIRTH 2-11-1914		6. AGE (In years lost birthday) 54 YRS.		IF UNDER YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign colony) Wash., D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.			
10. CITY OR TOWN OF DEATH Kenwood		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 6407 Brookside Drive		12a. USUAL OCCUPATION (Kind of work done during most of work on life, even if retired) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admittance on) STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Kenwood		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 6407 Brookside Drive	
14. FATHER'S NAME First Middle Last Peter Anderson			15. MOTHER'S MAIDEN NAME First Middle Last Grace Harden						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b. SOCIAL SECURITY NO. 578-03-3599		17. INFORMANT Redwing Rd., Bethesda, Md. Mrs. Peggy Ewing Lamb, Daughter, 6304					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) carcinomatosis 1147 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) adenocarcinoma of breast DUE TO, OR AS A CONSEQUENCE OF (c) 6 yrs.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 yr	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
9a. DATE OF OPERATION		9b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from July 1, 1967 to July 13, 1968 , that (I) was lost saw the deceased alive on July 13, 1968 , and that in (my) own opinion death occurred on the date and hour and from the causes stated above, (I) was (did) not view the body after death.									
22b. SIGNATURE Hill Carter MD DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>				22c. DATE SIGNED 7-13-68					
22d. PHYSICIAN'S NAME (Type) HILL CARTER				22e. ADDRESS 1835 Eye St NW					
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE 7-16-1968		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Suitland, Prince Georges Co. Md.			
24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc., N.W., Wash., D.C., 20016				ADDRESS 5130 Wisc. Ave.		25a. REC'D BY REG. STRAR JUL 17 1968		25b. REG. STRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers 1 and 2 and file them with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1 DECEASED-NAME (Type or print)			First	Middle	Last	2a DATE OF DEATH Month Day Year		2b HOUR AM PM			
Bruce Theodore Faatz						July 3 1968		5:20 AM			
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS			
Male		White		January 13, 1933		35 YRS					
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Washington, D. C.		USA				Montgomery Md.					
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b KIND OF BUSINESS OR INDUSTRY			
Bethesda			The Clinical Center, NIH			Usual: Bartender		--			
13a U.S. RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER		
Maryland			Montgomery		Rockville		YES		5709 Ridgeway Avenue		
14. FATHER'S NAME			First	Middle	Last	15 MOTHER'S MAIDEN NAME			First	Middle	Last
Harold T. Faatz						M. Lorraine					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b SOCIAL SECURITY NO.			17 INFORMANT The Medical Record Address The Clinical Center, Bethesda, Md. 20014					
No			577-42-5435								
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Edema DUE TO, OR AS A CONSEQUENCE OF Hodgkin's disease involving lungs, Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) kidneys, liver, pancreas, lymph nodes, bone marrow 5 1/2 years DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 24 hours		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (A) (this hospital) attended the deceased from May 19 19 68, to July 3 19 68, that (A) (we) lost saw the deceased alive on July 3 19 68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (A) (we) (did) (did not) view the body after death.											
22b SIGNATURE Ervin H. Epstein, M.D.					DEGREE		ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED 4 July 1968		
22d. PHYSICIAN'S NAME (Type) Ervin H. Epstein, Jr., M.D.					22e. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md.						
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)					
Cremation		7/5/68		Cedar Hill		Prince George County, Md.					
24. FUNERAL DIRECTOR Tyson Wheeler Funeral Home-1331 Rockville Pike Rockville, Md.					25a REC'D BY REGISTRAR JUL - 9 1968		25b REGISTRAR'S SIGNATURE Charles Judge				



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Charles E. Dr. Leaf *Medical N.D.*

10185

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

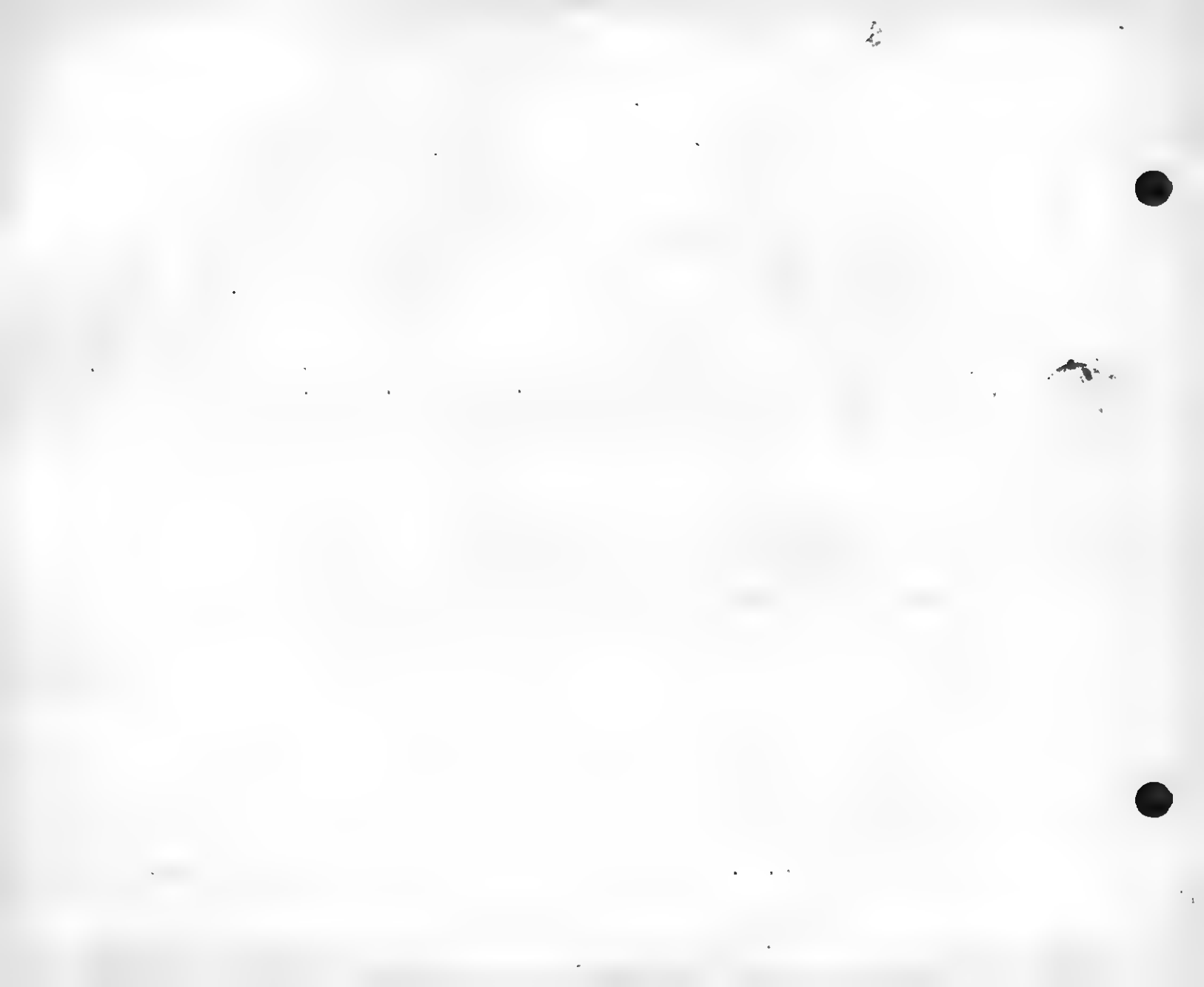
1. DECEASED-NAME (Type or print) First: Cecil Middle: Grace Last: <i>Jaris</i>			2a. DATE OF DEATH Month: 7 Day: 15 Year: 68			2b. HOUR 11 A M			
3. SEX Female		4. RACE White		5. DATE OF BIRTH 2/19/82		6. AGE (In years lost birthday) 86 YRS		7. IF UNDER 1 YEAR MONTHS: DAYS: HOURS: MIN:	
7a. BIRTHPLACE (State or foreign country) Belleville, Kansas		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md			
10. CITY OR TOWN OF DEATH Sil, Sprg		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Holy Cross		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) housewife		12b. KIND OF BUSINESS OR INDUSTRY Home			
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Sil. Sprg. Md.		13b. COUNTY Montgomery		13c. CITY OR TOWN SS		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 629 Whittingham Dr. S.S.Md.	
14. FATHER'S NAME First: Eli Middle: / Last: Haskett			15. MOTHER'S MAIDEN NAME First: Louisa Middle: / Last: Hicks						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no		16b. SOCIAL SECURITY NO (If yes give war or dates of service) yes		17. INFORMANT 629 Whittingham Dr. S.S.Md. daughter Mrs. Chester Callender					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Myocardial Infarct</i> 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>arteriosclerotic Cardio-Vascular Disease</i> 10 years DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>5mm -</i>									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>4101</i>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Port 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory) (Office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <i>Dec 1967</i> , to <i>July 15, 1968</i> , that (I) (was) last saw the deceased alive on <i>7-12-68</i> , and that in (my) (my) opinion death occurred on the date and hour and from the causes stated above, (I) (was) (did) (did not) view the body after death									
22b. SIGNATURE <i>George B. Patrick, Jr. M.D.</i>		22c. DATE SIGNED 7-15-68		22d. ADDRESS 9221 Colesville Rd., Silver Spring, Md.					
23a. BURIAL, CREMATION REMOVED (Specify)		23b. DATE Burial Cremation July 15, 1968		23c. NAME OF CEMETERY OR CREMATORY St. Lincoln Crematory		23d. LOCATION (City or Town) (County) (State) Prince George Co., Md.			
24. FUNERAL DIRECTOR <i>Clark E. Wison, Clerk</i>		24b. ADDRESS <i>Warner E. Pumphrey, Inc. Silver Spring, Md.</i>		25a. REC'D BY REGISTRAR DATE JUL 18 1968		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)			First Justine		Middle G.		Last FEIDT		2a. DATE OF DEATH Month 18 Day 68 Year		
3. SEX Female			4. RACE Caucasian		5. DATE OF BIRTH Jan. 28, 1918		6. AGE (In years lost birthday) 50 YRS.		2b. HOUR 235 P M		
7a. BIRTHPLACE (State or foreign country) New York			7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery		Md		
10. CITY OR TOWN OF DEATH Bethesda			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Naval Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife			12b. KIND OF BUSINESS OR INDUSTRY N/A		
13a. USUAL RESIDENCE (Where deceased admission) STATE Belgium			13b. COUNTRY lived, if institution: Residence before 13b. COUNTRY Brussels		13c. CITY OR TOWN Brussels		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 84 Blvd. Brand Whitlock		
14. FATHER'S NAME First Middle Last Gamung			15. MOTHER'S MAIDEN NAME First Middle Last Alice Bayless								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown () () () No			16b. SOCIAL SECURITY NO. none		17. INFORMANT Lounge, Dept. of State Wash. D.C. Mr. William E. Feidt, c/o Foreign Service						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinoma of breast associated with bronchial 174X DUE TO, OR AS A CONSEQUENCE OF pneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (b) (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 170:											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No			City or Town County State		
22a. I certify that (X) (this hospital) attended the deceased from June 21, 1968, to July 18, 1968, that (X) (we) lost saw the deceased alive on July 18, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (not) view the body after death.											
22b. SIGNATURE J.R. Fletcher						22c. DATE SIGNED July 19, 1968					
22d. PHYSICIAN'S NAME (Type) J. R. FLETCHER						22e. ADDRESS Naval Hospital, Bethesda, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 7/22/68		23c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery			23d. LOCATION (City or Town) (County) (State) Washington, D. C.			
24. FUNERAL DIRECTOR Robert A. Pumphrey ADDRESS Funeral Home, 7557 Wisconsin Ave., Bethesda						25a. REC'D BY REGISTRAR JUL 24 1968			25b. REGISTRAR'S SIGNATURE Charles Judge		



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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201													
10187 CERTIFICATE OF DEATH													
1 DECEASED-NAME (Type or print)			First Ernest		Middle C.		Last FERM		2a DATE OF DEATH Month 4 Day Year 68		2b HOUR A 9:00M		
3. SEX Male		4 RACE Caucasian			5. DATE OF BIRTH 30 July 1911			6. AGE (In years last birthday) 56 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN	
7a BIRTHPLACE (State or foreign country) Colorado		7b CITIZEN OF WHAT COUNTRY? USA			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Montgomery Md.					
7c CITY OR TOWN OF DEATH Bethesda			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Naval Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) U. S. Navy			12b. KIND OF BUSINESS OR INDUSTRY				
13a. USUAL RESIDENCE (Where deceased admission) STATE Virginia			3b. COUNTY Fairfax			13c. CITY OR TOWN Falls Church		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 2007 Oswald Place			
4 FATHER'S NAME First Nicander			Middle		Last FERM		15 MOTHER'S MAIDEN NAME First Evelina			Middle Johnson		Last	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes			16b. SOCIAL SECURITY NO. 1 Dec 43-4 Jul 68 522 07 22			17 INFORMANT Falls Church Va. Mrs. Helen FERM, 2007 Oswald Place							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Atherosclerotic cardiovascular disease with old 7101 DUE TO, OR AS A CONSEQUENCE OF and recent myocardial infarctions Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c) 421													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCAT ON Street or R.F.D. No		City or Town		County		State	
22a. I certify that (1) (this hospital) attended the deceased from May 30, 1968, to July 4, 1968, that (1) (we) last saw the deceased alive on July 4, 1968, and that in (1) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (do not) view the body after death.													
22b. SIGNATURE Charles S. Reeves MD						ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22c. DATE SIGNED 5 July 1968			
22d. PHYSICIAN'S NAME (Type) Charles S. Reeves, M. D.						22e. ADDRESS Naval Hospital, Bethesda, Md.							
23a. BURIAL, CREMATION, REMOVING (Specify) Burial			23b. DATE 7-8-68		23c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery, Arlington			23d. LOCATION (City or Town) Virginia		(County) (State)			
24. FUNERAL DIRECTOR W. W. Chambers Co. ADDRESS 1400 Chapin Street, N. W., Washington, D. C.						25a. REC'D BY REG. STRAR JUL - 9 1968		25b. REGISTRAR'S SIGNATURE Charles Judge					

CERTIFICATE OF DEATH

10188

10190

1. DECEASED NAME (Type or print) Irene Duval Forbes			2a. DATE OF DEATH Month July Day 3 Year 1968			2b. HOUR 1:15 P.			
3. SEX Female		4. RACE White		5. DATE OF BIRTH 9-9-02		6. AGE (In years last birthday) 65 YRS.		7. IF UNDER 1 YEAR MONTHS 0 DAYS 0 HOURS 0 MIN.	
7a. BIRTHPLACE (State or foreign country) Quebec, Canada		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md			
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Holy Cross Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 3304 Chiswick Ct.	
14. FATHER'S NAME First Josias Louis Middle Duval Last Duval			15. MOTHER'S MAIDEN NAME First Maude Middle Byrd Last Byrd			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No (If yes give war or dates of service)			
16b. SOCIAL SECURITY NO. -			17. INFORMANT Address Ct., Sil.Sp.Md. Dr. John C. Forbes, Husband, 3304 Chiswick						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Dissecting aortic aneurysm, with hemopericardium DUE TO, OR AS A CONSEQUENCE OF (b) hemothorax, left. DUE TO, OR AS A CONSEQUENCE OF (c) hemothorax, left. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. 19 Month 7 Day 6 Year 1968		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. 1131 City or Town Univ. Towers County Univ. Blvd. State S.S.		22a. I certify that (I) (this hospital) attended the deceased from 7-6-1968 , to 7-6-1968 , that (I) (we) last saw the deceased alive on 7-6-1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE Henry R. Wolfe		DEGREE M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 7/3/68			
22d. PHYSICIAN'S NAME (Type) Henry R. Wolfe		22e. ADDRESS 1131 Univ. Towers, Univ. Blvd., S.S.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 7-6-1968		23c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery		23d. LOCATION (City or Town) (County) (State) Rockville, Montgomery Co., Md			
24. FUNERAL DIRECTOR JOSEPH GAULIER'S SONS, INC.		ADDRESS 1730 WISC.		25a. REC'D BY REGISTRAR DAUL - 9 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																	
CERTIFICATE OF DEATH																	
1 DECEASED-NAME (Type or print)			First <i>Brothy</i>			Middle <i>Foster</i>			Last								
3 SEX <i>Female</i>			4 RACE <i>W</i>			5 DATE OF BIRTH <i>4/6/1913</i>			2a DATE OF DEATH Month <i>July</i> Day <i>18</i> Year <i>1968</i>								
7a BIRTHPLACE (State or foreign country) <i>Uganda</i>			7b CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> W DOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <i>Montgomery</i>								
10 CITY OR TOWN OF DEATH <i>Bethesda</i>			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban</i>			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Ret.</i>			12b KIND OF BUSINESS OR INDUSTRY <i>Govt.</i>								
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <i>Md</i>			13b COUNTY <i>Mont</i>			13c CITY OR TOWN <i>Bethesda</i>			13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>								
13e STREET AND NUMBER <i>4730 Bradley Blvd</i>			14 FATHER'S NAME First <i>Ware</i> Middle <i>Rose</i> Last <i>Greene</i>			15. MOTHER'S MAIDEN NAME First <i>Greene</i> Middle <i>Greene</i> Last <i>Greene</i>			16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i>								
16b SOCIAL SECURITY NO <i>-</i>			17. INFORMANT <i>Earl A. Foster, Husband</i>			Address <i>Same as #13</i>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinomatosis</i> <i>174X</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Carcinoma of left breast</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>last</i>										19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. <i>19</i>		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work										21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <i>January 1967</i> , to <i>July 18, 1968</i> , that (I) (we) last saw the deceased alive on <i>July 16, 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.										22b SIGNATURE <i>Howard E. Ticktin, MD</i>		22c DATE SIGNED <i>7-19-68</i>					
22d PHYSICIAN'S NAME (Type) <i>HOWARD E. TICKTIN, MD</i>										22e ADDRESS <i>916 19th St. NW. WASH. DC</i>		22f. LOCATION (City or Town) (County) (State) <i>Gordonsville, Virginia</i>					
23a BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>										23b DATE <i>7-23-1968</i>		23c NAME OF CEMETERY OR CREMATORY <i>Maplewood Cemetery</i>					
23d LOCATION (City or Town) (County) (State) <i>Gordonsville, Virginia</i>										23e NAME OF CEMETERY OR CREMATORY <i>Maplewood Cemetery</i>		23f. LOCATION (City or Town) (County) (State) <i>Gordonsville, Virginia</i>					
24. FUNERAL DIRECTOR <i>Joseph Bayler's Sons, Inc., 5130 Wisc. Ave. N.W., Wash., D.C., 20016</i>										25a REC'D BY REGISTRAR <i>JUL 23 1968</i>		25b REGISTRAR'S SIGNATURE <i>Charles Judge</i>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the top of page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print)		First	Middle	Last	2a DATE OF DEATH	2b HOUR
Venia Harrison Fraley					7 Month 6 Day 1968 Year	7 A M
3 SEX	4 RACE	5. DATE OF BIRTH		6 AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS	
Female	W	Jan. 1, 1884		84 YRS.	IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		
Md.	USA			Montgomery Md		
10 CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of work no life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY	
Derwood	6104 Muncaster Mill Rd.		H. Wife		Home	
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER		
Md.	Mont.	Derwood		6104 Muncaster Mill Rd.		
14 FATHER'S NAME	First	Middle	Last	15. MOTHER'S MAIDEN NAME First Middle Last		
Joseph			Harrison	Cornelia - Warthen		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO		17 INFORMANT Address		
no		220-44-2136		John Fraley Same as # 13		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Heart Failure</u>						1 mo
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic Heart Disease</u>						YRS
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Diabetes Mellitus</u>						YRS
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)						
<u>Collard Quatre</u>						
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC)		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 1956 to 7/6 1968, that (I) (we) last saw the deceased alive on 7/2 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE		DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c DATE SIGNED
E. H. Ligon, M.D.						7/6/68
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS				
E. H. Ligon, M.D.		Sandy Spring, Md 20860				
23a BURIAL, CREMATION, or other disposition (Specify)	23b DATE	23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)		
Burial	7-9-68	Rockville Union		Rockville, Mont. Md.		
24 FUNERAL DIRECTOR	25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE			
Francis H. Barber	Laytonville, Md. 20760		JUL - 9 1968		Charles Judge	



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PK-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED NAME (Type or Print)			First	Middle	Last	2a. DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> 7 27 68			2b HOUR 4:35 P
STEVEN			R. FRANKLIN						
3 SEX MALE	4 RACE CAUCASIAN	5. DATE OF BIRTH 5/31/42	6 AGE (in years last birthday) 26 YRS	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		2c DATE PRONOUNCED DEAD Month Day Year 7 27 68	2d HOUR 4:35
7a BIRTHPLACE (State or foreign country) Maryland		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery County			MD
10 CITY OR TOWN OF DEATH Silver Spring			11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Holy Cross Hospital			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) None			12b KIND OF BUSINESS OR INDUSTRY
13a USUAL RESIDENCE (Where deceased admission) STATE Wash. DC			13b COUNTY DC		13c CITY OR TOWN DC		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 5894 Eastern Ave., N.E.
14. FATHER'S NAME First Middle Last William M. Franklin			15 MOTHER'S MAIDEN NAME First Middle Last Shirley Franklin						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16b SOCIAL SECURITY NO (If yes give war or dates of service)		17 INFORMANT ADDRESS William M. Franklin - 5894 Eastern Ave., N.E.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Pulmonary Edema</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Larngo-tracheo Bronchitis Acute</u> DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>500 X</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day Year HOUR A.M. P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No		City or Town		County	State
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE EXAMINER'S NAME (Type)			Belden R. Reap M.D.			CHIEF MEDICAL EXAMINER. <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Give city, town, or county)			22b DATE SIGNED July 27, 1968
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE 7-29-68		23c NAME OF CEMETERY OR CREMATORY National Capitol Hebrew Cemetery		23d LOCATION City or Town Hillside, R.G., Md.		(County) (State)	
24 FUNERAL DIRECTOR Bernard Danzansky & Sons			ADDRESS 3501-14th Street N.W. Washington, D.C.			25a REC'D BY REG STRAR JUL 31 1968		25b REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 12 hours after death.

VR A15 (4)
30M REV 1/68

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED NAME (Type or print)			First Middle Last Georgia Burke Frantz			2a. DATE OF DEATH Month Day Year July 24 1968		2b. HOUR M	
3 SEX F		4. RACE W		5. DATE OF BIRTH Aug. 16, 1878		6. AGE (In years last birthday) 89 YRS		7. IF UNDER 1 YEAR MONTHS DAYS	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.			
10. CITY OR TOWN OF DEATH Gaithersburg		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Asbury Methodist Home		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) housewife		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. HAS DE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 4026 Hayward Avenue	
14. FATHER'S NAME First Middle Last Daniel Hoffman			15. MOTHER'S MAIDEN NAME First Middle Last Mary E. Sipes						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no		16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 220-54-1646-T		17. INFORMANT Address Asbury Methodist Home, Gaithersburg, Md.					
18. CAUSE OF DEATH (Enter only one cause per line, or (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Cerebrovascular Thrombosis</u> 453.9 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral Arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 mo. 5 yrs.									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
21d. INJURY OCCURRED White <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>4/11/63</u> , 19__, to <u>7/24/68</u> , 19__, that (I) (we) last saw the deceased alive on <u>7/23/68</u> , 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Henry C. Scruggs MD</u>		DEGREE MD		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <u>7/24/68</u>			
22d. PHYSICIAN'S NAME (Type) <u>HENRY C. SCRUGGS MD</u>		22e. ADDRESS <u>5413 Cedar Lane Bethesda Md.</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>7/26/68</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Daniel Ridge Ave.</u>		23d. LOCATION (City or Town) (County) (State) <u>Pikesville Md.</u>			
24. FUNERAL DIRECTOR <u>Wm J. Tucker & Sons Bal. Md.</u>				25a. REC'D BY REGISTRAR <u>DATE JUL 30 1968</u>		25b. REGISTRAR'S SIGNATURE <u>John Charles Judge</u>			

MEDICAL CERTIFICATION



CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR P	
Charles			(none)		Friedman	July 21 1968			5:20 M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years lost birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.
Male		White		20 May 1916		52 YRS.				
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Philadelphia Pennsylvania		USA				Montgomery Md.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY	
Bethesda			The Clinical Center, NIH			Salesman			INSTALLMENT	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER
Pennsylvania						Philadelphia		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		6044 North 11th Street
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME							
First Middle Last			First Middle Last							
Louis Friedman			Fannie Fexelblatt							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.			17. INFORMANT The Medical Record Address				
No			161-10-8000			The Clinical Center, NIH, Bethesda, Maryland				
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial Failure										3-4 years
DUE TO, OR AS A CONSEQUENCE OF (b) Aortic and mitral valve disease										years
DUE TO, OR AS A CONSEQUENCE OF (c) Cystic medial necrosis										years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Chronic lung disease, hypertensive cardiovascular disease										
18a. DATE OF OPERATION		18b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes				
9/8/67 & 11/29/67		Aortic aneurysm, aortic insufficiency, mitral insufficiency		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED White <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (X) (this hospital) attended the deceased from 13 July 1968, to 21 July 1968, that (X) (we) lost saw the deceased alive on 21 July 1968, and that in (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (not) view the body after death.										
22b. SIGNATURE Lynn M. Petersom		DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED 21 July 1968						
22d. PHYSICIAN'S NAME (Type)		Lynn M. Petersom, M.D.		22e. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Maryland						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
BURIAL		7-23-68		MT. SHARON		DELAWARE COUNTY, PA.				
24. FUNERAL DIRECTOR ADDRESS				25a. REC'D BY REGISTRAR DATE		25b. REGISTRAR'S SIGNATURE				
SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD				JUL 23 1968		J. Charles Jones				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) TILLIE			First Middle Last FRIEDMAN			2a. DATE OF DEATH Month 7 Day 19 Year 68			2b. HOUR 3:20 PM		
3 SEX F			4 RACE W			5 DATE OF BIRTH 5/1/86			6 AGE (In years last birthday) 82 YRS		
7a. BIRTHPLACE (State or foreign country) Russia			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH Montgomery Md.		
10 CITY OR TOWN OF DEATH SILVER SPRING			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) NEW CROSS HOSP.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE WASH. D.C.			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
13e. STREET AND NUMBER 1721 VERBENA ST N.W.			13f. CITY OR TOWN WASH. D.C.			13g. STATE			13h. ZIP CODE		
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) NO			16b. SOCIAL SECURITY NO		
17. INFORMANT GARLICK FUNERAL HOME			Address BROOKLYN, NY 1700 CUNY ISLAND AVE			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE 4120 DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIO SCLEROTIC HEART DISEASE 4200 DUE TO, OR AS A CONSEQUENCE OF (c)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 96 hours		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) NEPHROSCLEROSIS											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from OCT 1963 to 7/17, 1968 , that (I) (we) last saw the deceased alive on 7/17, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE DR. MORTON SHAPIRO						DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>			22c. DATE SIGNED 7/17/68		
22d. PHYSICIAN'S NAME (Type) DR. MORTON SHAPIRO						22e. ADDRESS					
23a. (BURIAL, CREMATION, REMOVAL) (Specify)			23b. DATE July 19-68			23c. NAME OF CEMETERY OR CREMATORY OLD MONTEFIORE			23d. LOCATION (City or Town) (County) (State) SPRING FIELD GARDEN N.Y.		
24. FUNERAL DIRECTOR GARLICK FUNERAL HOME			ADDRESS FOREST HILLS, N.Y.			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE Charles J. Jones		
DATE JUL 22 1968											

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 151
30M REV. 1-68

10195

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print) EDNA			First	Middle	Last	2a. DATE OF DEATH Month July Day 3 Year 1968			2b. HOUR 9:50 AM			
3 SEX Female		4 RACE White		5 DATE OF BIRTH 11/8/11			6 AGE (in years last birthday) 56 YRS.		7 UNDER 1 YEAR MONTHS DAYS HOURS MIN			
7a BIRTHPLACE (State or foreign country) Maryland		7b CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Montgomery Md.					
10 CITY OR TOWN OF DEATH Bethesda			11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Suburban			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY			
13a. US-JAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Md			13b. COUNTY Montgomery			13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 1004 De Beaulieu Dr.		
14 FATHER'S NAME First John Middle H Last Poole			15 MOTHER'S MAIDEN NAME First Margaret Middle M Last Crown									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO. 214-48-7316			17. INFORMANT 1541 Brentwood Rd. Rockville Md. Mrs. Mary F. ...						
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Primary Carcinoma of Liver (Hepatic) 1550 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 18 mos.			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 1551												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from March, 1967 , to 7/3, 1968 , that (I) (we) last saw the deceased alive on July 3, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE Arthur F. Woodward						DEGREE MD		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 7/3/68		
22d. PHYSICIAN'S NAME (Type) Arthur F. Woodward						22e. ADDRESS Rockville - Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE 7/9/68			23c. NAME OF CEMETERY OR CREMATORY Dorwood Cemetery			23d. LOCATION (City or Town) (County) (State) Dorwood Montgomery, Md.			
24. FUNERAL DIRECTOR Tyson Funeral						ADDRESS 1 Rock Pike Rockville, Md.			25a. REC'D BY REGISTRAR JUL - 9 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

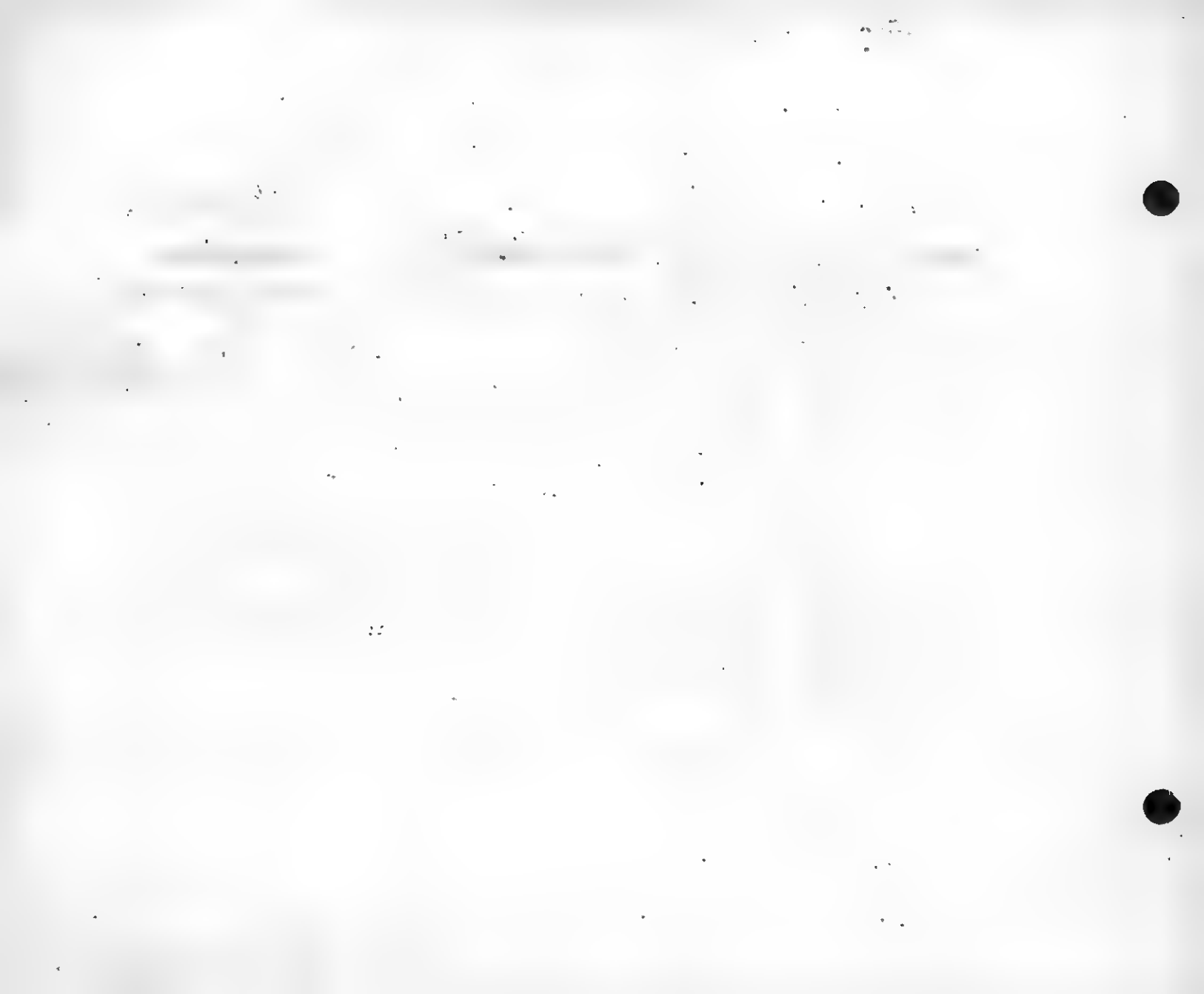
(M)

10196

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1006

1 DECEASED-NAME (Type or print) First Middle Last William M Gannon			2a DATE OF DEATH Month Day Year July 10 1968			2b. HOUR 2:45 PM	
3. SEX FEMALE		4 RACE WHITE		5 DATE OF BIRTH AUGUST 4, 1879		6 AGE (In years last birthday) 88 YRS.	
7a BIRTHPLACE (State or foreign country) NEW YORK		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH MONTGOMERY MD	
10 CITY OR TOWN OF DEATH TAKOMA PARK		11 NAME OF HOSPITAL OR INSTITUTION (If not a hospital, give street address) CEAR HAVENREST HOME 7300 BALTIMORE AVE		12a USUAL OCCUPATION (Kind of work done during last months of working life, even if retired) HOUSEWIFE		12b KIND OF BUSINESS OR INDUSTRY	
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE MARYLAND		13b. COUNTY MONTGOMERY		13c CITY OR TOWN TAKOMA PARK		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e STREET AND NUMBER 503 THILADELPHIA AVE		14. FATHER'S NAME First Middle Last Peter Nutz		15. MOTHER'S MAIDEN NAME First Middle Last Sarah Jane Miller			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO		16b. SOCIAL SECURITY NO		17 INFORMANT Address MRS. EARL FUNK 18015 BRUNETT AVE. SILVER SPRING MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Embolism Brain (Pulmonary) DUE TO, OR AS A CONSEQUENCE OF (b) Heart Fibrillation DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7/4/68 34 days
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c) 4-23							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.)		21f LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 10/17/67, 1967, to 7/10/68, 1968, that (I) (we) lost saw the deceased alive on 7/10/68, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b SIGNATURE Howard T. Morse				DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 7/14/68	
22d. PHYSICIAN'S NAME (Type) Howard T. Morse				22e ADDRESS 2030 Cornell Ave Takoma Park Md			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE July 15, 1968		23c NAME OF CEMETERY OR CREMATORY Forest Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Utica New York	
24. FUNERAL DIRECTOR Arthur Walters, 257 Canal St NW.				25a. REC'D BY REGISTRAR JUL 15 1968		25b REGISTRAR'S SIGNATURE Charles Judge	



DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or Print) SOLEDAO			2a. DATE KNOWN OF DEATH 7-38 19 68			2b. HOUR M		
3 SEX Fe	4 RACE CAUC.	5 DATE OF BIRTH Sept. 1898	6 AGE (In years last birthday) 69 YRS	7 UNDER 1 YEAR MONTHS DAYS 	7 UNDER 24 HRS. HOURS MIN. 	2c. DATE PRONOUNCED DEAD 8-1 19 68 2d HOUR 830 P		
7a. BIRTHPLACE (State or foreign country) PANAMA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md		
10 CITY OR TOWN OF DEATH SILVER SPRING			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 935 BONIFANT ST.			2a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) SEAMSTRESS		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if not in hospital, residence before admission) STATE MD			13b. COUNTY MONTGOM. S.S.			13c. INS. DE. CITY, JM. IS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 935 BONIFANT ST.
14 FATHER'S NAME First Alejandro Ramos Middle Last 				15. MOTHER'S MAIDEN NAME First Unknown Middle Last 				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no or unknown) no (If yes give war or dates of service)			16b. SOC. SEC. NO. 578-01-1250		17 INFORMANT Stanley Dougherty ADDRESS 1126 Hornell Dr., S. S. Md.			
18 CAUSE OF DEATH (Enter only one cause per part for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Coronary Insufficiency DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) 								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 								
19a. DATE OF OPERATION 			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? 			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH 			21b. TIME OF INJURY Month, Day, Year 19 HOUR A.M. P.M. 		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) 			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) 		21f. LOCATION Street or R.F.D. No. City or Town County State 				
22a. I certify that I took charge of the remains described above held on death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion								
ACTUAL SIGNATURE Belden R. Keap M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED Aug. 1, 1968		
EXAMINER'S NAME (Type) BELDEN R. KEAP			DEPUTY MED. CA. EXAMINER <input checked="" type="checkbox"/>			ADDRESS (Street, City, Town or County) 		
23a. BURIAL, CREMATION, REMOVAL (Specify) cremation		23b. DATE Aug. 2, 1968		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Crematory		23d. LOCATION (City or Town) (County) (State) Bladensburg P.G. County Md.		
24 FUNERAL DIRECTOR Charles E. Pumphrey, Inc., 8434 Ga. Ave., S.S. Md.				25a. REC'D BY REGISTRAR AUG 5 1968		25b. REGISTRAR'S SIGNATURE Charles Judge		

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

10199
 MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
 Item 13 Film 6401 8/26/68
 CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) Rose			First Middle Last			2a. DATE OF DEATH Month Day Year July 4 / 1968			2b. HOUR 14		
3 SEX Female			4 RACE Caucasian			5. DATE OF BIRTH 7/10/1901			6. AGE (In years last birthday) 67 YRS.		
7a. BIRTHPLACE (State or foreign country) Poland			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Montgomery Md.		
10. CITY OR TOWN OF DEATH Wheaton			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Kenneth H. Hulse Nursing Home			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Saleslady			12b. KIND OF BUSINESS OR INDUSTRY Retail		
13a. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) STATE Florida			13b. COUNTY Dade			13c. CITY OR TOWN Miami Beach			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
13e. STREET AND NUMBER 4006 Tenth St			13f. CITY OR TOWN Hotel			13g. STREET AND NUMBER 4006 Tenth St			13h. CITY OR TOWN Hotel		
14. FATHER'S NAME First Middle Last ISAAC SHUSTER			15. MOTHER'S MAIDEN NAME First Middle Last MOLLIE			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. —		
16c. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)			16d. SOCIAL SECURITY NO. —			17. INFORMANT Donald J. Gensby			Address 4006 Tenth St Wheaton Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory depression DUE TO, OR AS A CONSEQUENCE OF (b) wid spread metastasis & debilitati DUE TO, OR AS A CONSEQUENCE OF (c) Epithelioma L. hip. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Months Months	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 1967											
19a. DATE OF OPERATION 1967			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 6/14 , 1968 , to 7/4 , 1968 , that (I) (we) last saw the deceased alive on 7/2 , 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Richard P. Delaney, MD						ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>			22c. DATE SIGNED 7/9/68		
22d. PHYSICIAN'S NAME (Type) Richard P. Delaney, MD						22e. ADDRESS 4323 Harward, S. Lee Spring, Md					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE 7/5/68			23c. NAME OF CEMETERY OR CREMATORY Beth DAVID Cem.			23d. LOCATION (City or Town) (County) (State) ELMONT, NY		
24. FUNERAL DIRECTOR D. Gensby + Sons 3521-14th St N.W. Wash. D.C.						25a. REC'D BY REGISTRAR JUL - 8 1968			25b. REGISTRAR'S SIGNATURE John Charles Judge		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
CERTIFICATE OF DEATH												
1. DECEASED-NAME (Type or print) First Middle Last <i>Herma Baby Girl</i>						2a. DATE OF DEATH Month <i>7</i> Day <i>30</i> Year <i>68</i>			2b. HOUR <i>3:00 P.M.</i>			
3 SEX <i>Female</i>		4. RACE <i>white</i>		5. DATE OF BIRTH <i>July 29, 1968</i>		6. AGE (In years last birthday) YRS MONTHS DAYS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MINS.		
7a. BIRTHPLACE (State or foreign country) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery Co., Md.</i>						
10. CITY OR TOWN OF DEATH <i>Bethesda</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban</i>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>NONE</i>			12b. KIND OF BUSINESS OR INDUSTRY —			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <i>Maryland</i>				13b. COUNTY <i>Montgomery</i>		13c. CITY OR TOWN <i>Potomac</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>2501 Chillum Place</i>		
14. FATHER'S NAME First Middle Last <i>Fredrick Squires Herma</i>				15. MOTHER'S MAIDEN NAME First Middle Last <i>Dorothy Gene Clark</i>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) <i>NO</i>				16b. SOCIAL SECURITY NO. <i>NONE</i>		17. INFORMANT Address <i>Birth Certificate</i>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral anoxia</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Aspiration atelectasis</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Fetal distress in utero</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>30 hrs</i> <i>30 hrs</i>		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>None</i>												
19a. DATE OF OPERATION —		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED —				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18.) —								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC. —		21f. LOCATION Street or R.F.D. No. City or Town County State —								
22a. I certify that (I) (this hospital) attended the deceased from <i>7-28</i> , 19 <i>68</i> , to <i>7-30</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>7-30</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <i>Richard M. Auld</i>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>7-30-68</i>				
22d. PHYSICIAN'S NAME (Type) <i>RICHARD M. AULD</i>						22e. ADDRESS <i>809 Viers Mill Rd, Rockville</i>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>8/2/68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Mt. Olivet Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Washington, D.C.</i>						
24. FUNERAL DIRECTOR <i>ROBERT A. PUMPHREY, Bethesda, Maryland</i>						25a. REC'D BY REGISTRAR <i>7557 Wisconsin Ave.</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>				
DATE <i>AUG 5 1968</i>												



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED NAME (Type or print)			First	Middle	Lost	2a. DATE OF DEATH Month <u>7</u> Day <u>19</u> Year <u>68</u>		2b. HOUR <u>3:45</u> P.		
3. SEX F.			4. RACE white		5. DATE OF BIRTH April 3, 1875		6. AGE (In years last birthday) 93 YRS.		IF UNDER 1 YEAR MONTHS DAYS	
7a. BIRTHPLACE (State or foreign country) Wash., D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.				
10. CITY OR TOWN OF DEATH Rockville, Md.			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Potomac Valley Nursing Home			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife		12b. KIND OF BUSINESS OR INDUSTRY At Home		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE 4000 Mass. Ave.			13b. COUNTY Wash. D. C.		13c. CITY OR TOWN Wash. D. C.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 4000 Mass. Ave.	
14. FATHER'S NAME First <u>John</u> Middle <u>Bray</u> Last <u>Bray</u>			15. MOTHER'S MAIDEN NAME First <u>Ellen</u> Middle <u>S.</u> Last <u>Spofford</u>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or Unknown <input checked="" type="checkbox"/> (If yes give war or dates of service)				
16b. SOCIAL SECURITY NO. 711-12-3257			17. INFORMANT <u>M. Peterson R. N. 12221 River Rd.</u>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: 4379 IMMEDIATE CAUSE (a) <u>Arteriosclerosis generalized and cerebral</u> 3 yrs. DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>3-24-68</u>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Bronchitis, chronic recurrent.</u>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <u>19</u>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <u>12-28, 1967</u> to <u>7-19, 1968</u> , that (I) (we) last saw the deceased alive on <u>7-9, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>Thomas A. Wildman, M.D.</u>					22c. DATE SIGNED <u>7-19-68</u>		22d. PHYSICIAN'S NAME (Type) <u>Thomas A. Wildman, M. D.</u>			
22e. ADDRESS <u>2032-16th St. N.W. Wash. D.C.</u>					22f. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>July 22, 1968</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Bladensburg Maryland PGCo.</u>		24. FUNERAL DIRECTOR <u>Joseph Gawler's Sons 5130 Wisconsin Ave NW Wash DC</u>		
25a. REC'D BY REGISTRAR <u>JUL 23 1968</u>					25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>					



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Body delivered per Dr. Reap - 1968

MAY 18-22-68 film 403 MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or Print) Robert Gerber						2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MATED <input type="checkbox"/> 7 22 68		2b. HOUR 6:02			
3. SEX Male		4. RACE white		5. DATE OF BIRTH 8/16/96		6. AGE (In years last birthday) 71 YRS		IF UNDER 1 YEAR MONTHS 0 DAYS 0		F UNDER 24 HRS HOURS 0 MIN 0	
7a. BIRTHPLACE (State or foreign country) Russia			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery		2d. HOUR 6.00	
10. CITY OR TOWN OF DEATH Silver Spring, Md.				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Holy Cross Hospital				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Chrmn Brd. Drug Fair		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Wash. DC				13b. COUNTY DC		13c. CITY OR TOWN Wash. DC		3d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 4201 Cathedral Ave. NW DC	
14. FATHER'S NAME First Israel Middle Gerber Last Gerber				15. MOTHER'S MAIDEN NAME First Rachel Middle Feldman Last Feldman							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16b. SOCIAL SECURITY NO. 216-05-2736		17. INFORMANT Myron Dave Gerber, 7536 Hampden Lane Bethesda, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a) (b) and (c))											
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Contussions and Multiple											
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
(b) Gastrointestinal ulcer with hemorrhage											
DUE TO, OR AS A CONSEQUENCE OF											
(c) secondary to trauma											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year 7-10-68 HOUR A.M. PM		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) deceased drove his car into a stopped truck					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) highway		21f. LOCATION Street or R.F.D. No Shirley Hwy City or Town Arlington County Va. State Va.							
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Belden R. Reap		EXAMINER'S NAME (Type) BELDEN R. REAP M.D.		22b. DATE SIGNED July 22, 1968							
23a. B. URIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 7/24/68		23c. NAME OF CEMETERY OR CREMATORY V. ash. Hebrew Congre. Cemetery		23d. LOCATION (City or Town) Washington, D.C. (County) D.C. (State) D.C.					
24. FUNERAL DIRECTOR Bernard Danzansky & Sons, 3501 14th St. NW, Washington, D.C.		25a. RECD BY REGISTRAR JUL 25 1968		25b. REGISTRAR'S SIGNATURE Charles Judge							



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in parenthesis in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

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10202

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or Print) First Middle Last Robert Edward XXXXXX GLAZE			2a DATE KNOWN OF DEATH <input type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year <input type="checkbox"/> 2b HOUR <input type="checkbox"/> M		
3 SEX Male	4 RACE White	5 DATE OF BIRTH 11/30/39	6 AGE (In years last birthday) 28 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	IF UNDER 24 HRS HOURS MIN
7a BIRTHPLACE (State or foreign country) Washington, D.C. USA		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10 CITY OR TOWN OF DEATH Takoma Pk.		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Wash San & Hospital		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Sheet metal	
13a USUAL RESIDENCE (Where deceased lived, if institution residence before admission) Maryland		13b CITY OR TOWN Montgomery Silver Sp.		13c INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME First Middle Last Leroy S. Glaze		15 MOTHER'S MAIDEN NAME First Middle Last Mildred Henderson			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16b SOCIAL SECURITY NO		17 INFORMANT ADDRESS Leroy S. Glaze - Item # 13	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Occlusion of Anterior Descending DUE TO, OR AS A CONSEQUENCE OF Branch, left Coronary Artery (b) Coronary Artery Heart Disease DUE TO, OR AS A CONSEQUENCE OF Coronary Artery Heart Disease (c) Coronary Artery Heart Disease PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 4201					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No City or Town County State	
22a. I certify that, I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Belden R. Keap		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED July 24, 1968	
EXAMINER'S NAME (Type) BELDEN R. KEAP M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		ADDRESS (City or Town) (County) (State) Rockville, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 7/27/68		23c. NAME OF CEMETERY OR CREMATORY Parklawn	
23d. LOCATION (City or Town) (County) (State) Rockville, Maryland		23e. REC'D BY REGISTRAR JUL 30 1968		23f. REGISTRAR'S SIGNATURE Charles Judge	

Tyson Wheeler Funeral Home-1331 Rockville Pike
Rockville, Maryland

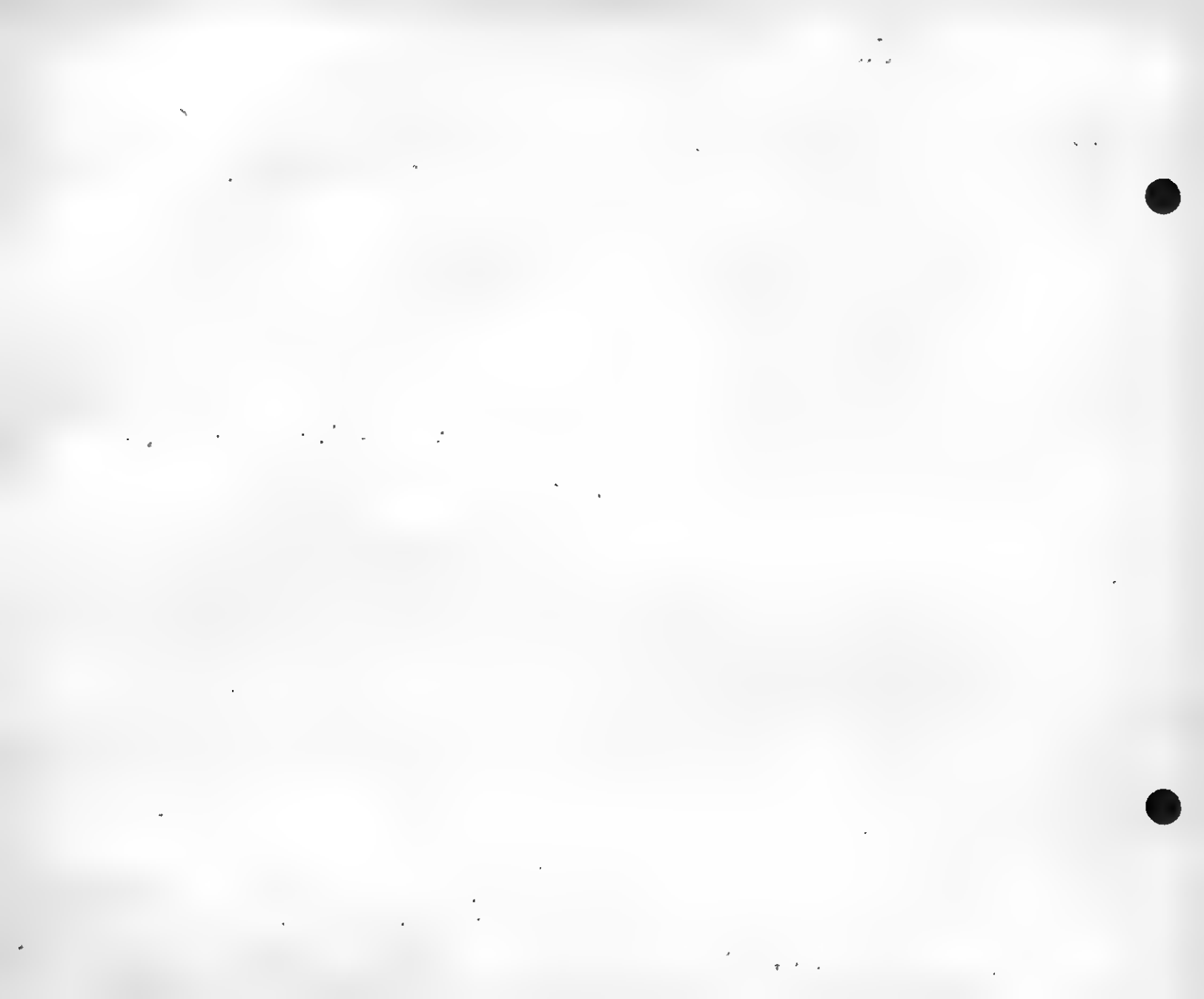


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 1512
30M REV 1/68

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201													
CERTIFICATE OF DEATH													
1. DECEASED-NAME (Type or print) <i>Baby Godwin</i>						2a. DATE OF DEATH Month <i>7</i> Day <i>7</i> Year <i>68</i>		2b. HOUR <i>7:30</i> M					
3 SEX <i>F</i>		4 RACE <i>W</i>		5 DATE OF BIRTH <i>7-6-68</i>		6 AGE (in years lost birthday) YRS. MONTHS DAYS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN			
7a. BIRTHPLACE (State or foreign country) <i>MD.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <i>Montgomery</i> Md.							
10. CITY OR TOWN OF DEATH <i>Bethesda</i>				11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban</i>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)				12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUA. RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <i>MD.</i>				13b. COUNTY <i>Mont.</i>		13c. CITY OR TOWN <i>Silver Spring</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>804 University Blvd. Apt. 5</i>			
14. FATHER'S NAME First Middle Last				15. MOTHER'S MAIDEN NAME First Middle Last <i>Frances Jane Godwin</i>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown				16b. SOCIAL SECURITY NO		17. INFORMANT Address							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))													
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Respiratory Death - Hyaline Membrane</i> 12 hrs													
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Pulmonary Atelectasis</i>													
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Prematurity</i>													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
MEDICAL CERTIFICATION													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING ETC				21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <i>Frances J. Froendle</i> MD				DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>			
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS									
22c. DATE SIGNED <i>7-7-68</i>													
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE <i>7/8/68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Suburban Hospital</i>		23d. LOCATION (City or Town) (County) (State) <i>Bethesda - Montg. Md</i>					
24. FUNERAL DIRECTOR <i>Mrs. Amelia Carter - Administrator</i>				ADDRESS		25a. REC'D BY REGISTRAR DATE <i>JUL 15 1968</i>		25b. REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) Ruth H. Gold.			2a. DATE OF DEATH Month 7 Day 4 Year 1968			2b. HOUR 9:15A.M.				
3. SEX F.		4 RACE White		5 DATE OF BIRTH 6-13-88		6 AGE (In years last birthday) 80 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) N.Y.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH MONTG. COUNTY Md.				
10 CITY OR TOWN OF DEATH Silver Spring			11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Holy Cross			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.			13b. COUNTY MONTG.			13c. CITY OR TOWN Silver Spring			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME First Middle Last HIRSCH			15 MOTHER'S MAIDEN NAME First Middle Last HOFFER PESSER			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)				
16b. SOCIAL SECURITY NO. 579-34-9723			17 INFORMANT LEWIS GOLD - SON			Address 8209 RAYMOND LANE POTOMAC, MD.				
18 CAUSE OF DEATH (Enter only one cause per line, for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) LIVER & RENAL FAILURE 114X DUE TO, OR AS A CONSEQUENCE OF (b) METASTATIC CARCINOMA DUE TO, OR AS A CONSEQUENCE OF (c) CARCINOMA OF BREAST APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 48-72 HRS. 5 YRS. 7 YRS.										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Hiatal Hernia - Large. Generalized Atherosclerosis										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from MAY 15, 1963 , to JULY 4, 1968 , that (I) (we) lost saw the deceased alive on JULY 3, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Harold Steeling MD			DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED 7/4/68				
22d. PHYSICIAN'S NAME (Type) HAROLD STEELING MD			22e. ADDRESS 1352 UNIVERSITY BLVD #8							
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE July 5, 1968			23c. NAME OF CEMETERY OR CREMATORY George Washington Cemetery			23d. LOCATION (City or Town) (County) (State) Hyattsville, Maryland	
24. FUNERAL DIRECTOR Donald M. Stein			ADDRESS 232 Carroll St., N.W. - Wash. D.C.			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Dr. Dan D. M. E. Mont. Co. Notified & Approved

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH		2b. HOUR	
EHA Goldstein						7 Month 20 Day 68		4:30 P.M.	
3 SEX	4 RACE		5 DATE OF BIRTH			6 AGE (In years last birthday)		IF UNDER 1 YEAR	
Female	Jewish		3/11/1886			52 YRS.		MONTHS DAYS HOURS MIN.	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Russia		USA				Montgomery Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
Bethesda			Crescent House			housewife			
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE			13b. CITY OR TOWN		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER		
4963 Crescent Dr. Bethesda Md.			Md.				Crescent St. 4963		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
UNKNOWN			UNKNOWN						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown			16b. SOCIAL SECURITY NO.		17. INFORMANT				
No			577-03-11280		Sam Goldstein Same As 13				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) CARCINOMATOSIS									9 MO
DUE TO, OR AS A CONSEQUENCE OF									
(b) CA of L Colon									2 YRS
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		HOUR A.M. Month Day Year							
21d. INJURY OCCURRED		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>									
22a. I certify that (I) (this hospital) attended the deceased from June 1964 to 7-20-1968, that (I) (we) last saw the deceased alive on 7/11/68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE				DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED	
Lewis H. Biben								7-20-68	
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS					
LEWIS H. BIBEN, M.D.				916 19th St NW		WASHINGTON DC			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		7-22-68		BETH SHOLOM CEM		CAPITOL HEIGHTS MD			
24. FUNERAL DIRECTOR				ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Goldstein & Son				4217 9th St. N.W.		JUL 23 1968		J. Charles Judge	



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal and in any event within 72 hours after death.

Items 21d-22a Film 40 Maryland State Department of Health
9-10-68 ams DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED NAME (Type or Print) JAMES Robert GOODMAN			2a DATE KNOWN OF DEATH: <input checked="" type="checkbox"/> Month July Day 5 Year 1968			2b HOUR 8:45 PM		
3 SEX M	4 RACE W	5 DATE OF BIRTH April 15 1935	6 AGE (in years and birthday) 33 YRS	7 UNDER 1 YEAR MONTHS 0 DAYS 0	8 UNDER 24 HRS HOURS 0 MIN 0	2c DATE PRONOUNCED DEAD Month 7 Day 5 Year 1968		
7a BIRTHPLACE (State or foreign country) Washington, D.C.		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Prince Georges		
10 CITY OR TOWN OF DEATH Silver Spring		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Walter Reed Hospital		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Equipment Operator		12b KIND OF BUSINESS OR INDUSTRY Greenbelt		
13a USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE Md		13b COUNTY Prince Georges		13c CITY OR TOWN Greenbelt		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 64 Parkway SE
14 FATHER'S NAME First Morris Middle Goodman Last Goodman			15 MOTHER'S MAIDEN NAME First Winifred Middle Unknown Last Unknown					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES		16b SOCIAL SECURITY NO. 1950 264-52-6551		17 INFORMANT Norma L. Goodman		ADDRESS Same as above #13		
18 CAUSE OF DEATH (Enter only one cause per line for (a) (b) and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Broncho Pneumonia Bilateral								
DUE TO, OR AS A CONSEQUENCE OF (b) Multiple Gunshot wounds Penetrating skull and chest (left)								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a DATE OF OPERATION 8/1			19b CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b TIME OF INJURY Month, Day, Year 19 HOUR A.M. 19 P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) Gun Shot				
21d INJURY OCCURRED <input type="checkbox"/> WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Restaurant		21f LOCATION Street or R.F.D. No Bladensburg City or Town Prince Geo. County Md. State Md.				
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE Dayton O Watkins		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		7-6-68		
EXAMINER'S NAME (Type) DAYTON O WATKINS				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		22b DATE SIGNED		
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		5318 Annapolis Rd		
				ADDRESS (Street, city, town, or county) Bladensburg Md				
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE July 11 1968		23c NAME OF CEMETERY OR CREMATORY Baltimore National		23d LOCATION (City or Town) Baltimore (County) Md (State) Md		
24. FUNERAL DIRECTOR F. Gasch's Son				ADDRESS Hyattsville, Md		25a. REC'D BY REG STRAR DATE 111 12 1968		25b. REGISTRAR'S SIGNATURE Charles Judge



CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) MARTHA Mary Green			2a. DATE OF DEATH Month July Day 22 Year 1968			2b. HOUR 3:30 M.					
3 SEX Female		4 RACE white		5 DATE OF BIRTH July 22, 1968		6 AGE (In years last birthday) — YRS.		IF UNDER 1 YEAR MONTHS — DAYS —		IF UNDER 24 HRS. HOURS 2 MIN 40	
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Montgomery County Md.					
10 CITY OR TOWN OF DEATH Silver Spring			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Holy Cross Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) —			12b. KIND OF BUSINESS OR INDUSTRY —		
13a. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE MARYLAND			13b. COUNTY Montgomery		13c. CITY OR TOWN Beltsville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 1312 Arcola Ave.		
14. FATHER'S NAME First Middle Last Kenneth Ernest Green			15. MOTHER'S MAIDEN NAME First Middle Last Shirley Lavona Cline								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No			16b. SOCIAL SECURITY NO —			17. INFORMANT Shirley Cline Address — City — State — Zip 27					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Premature birth, neonatal death 486 X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) — DUE TO, OR AS A CONSEQUENCE OF (c) —										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH —	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Possible intrauterine pneumonia											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Nat white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from 7/22 , 19 68 , to 7/22 , 19 68 ; that (I) (we) last saw the deceased alive on 7/22 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Donald Straus						DEGREE MD		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 7/22/68	
22d. PHYSICIAN'S NAME (Type) Donald Straus, M.D.						22e. ADDRESS 4301 Aspen Hill Rd., Rockville, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 7/22/68		23c. NAME OF CEMETERY OR CREMATORY Rockville		23d. LOCATION (City or Town) (County) (State) Rockville, Maryland					
24. FUNERAL DIRECTOR Tyson Wheeler Funeral Home						ADDRESS Rockville, Md.		25a. REC'D BY REGISTRAR DATE JUL 30 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

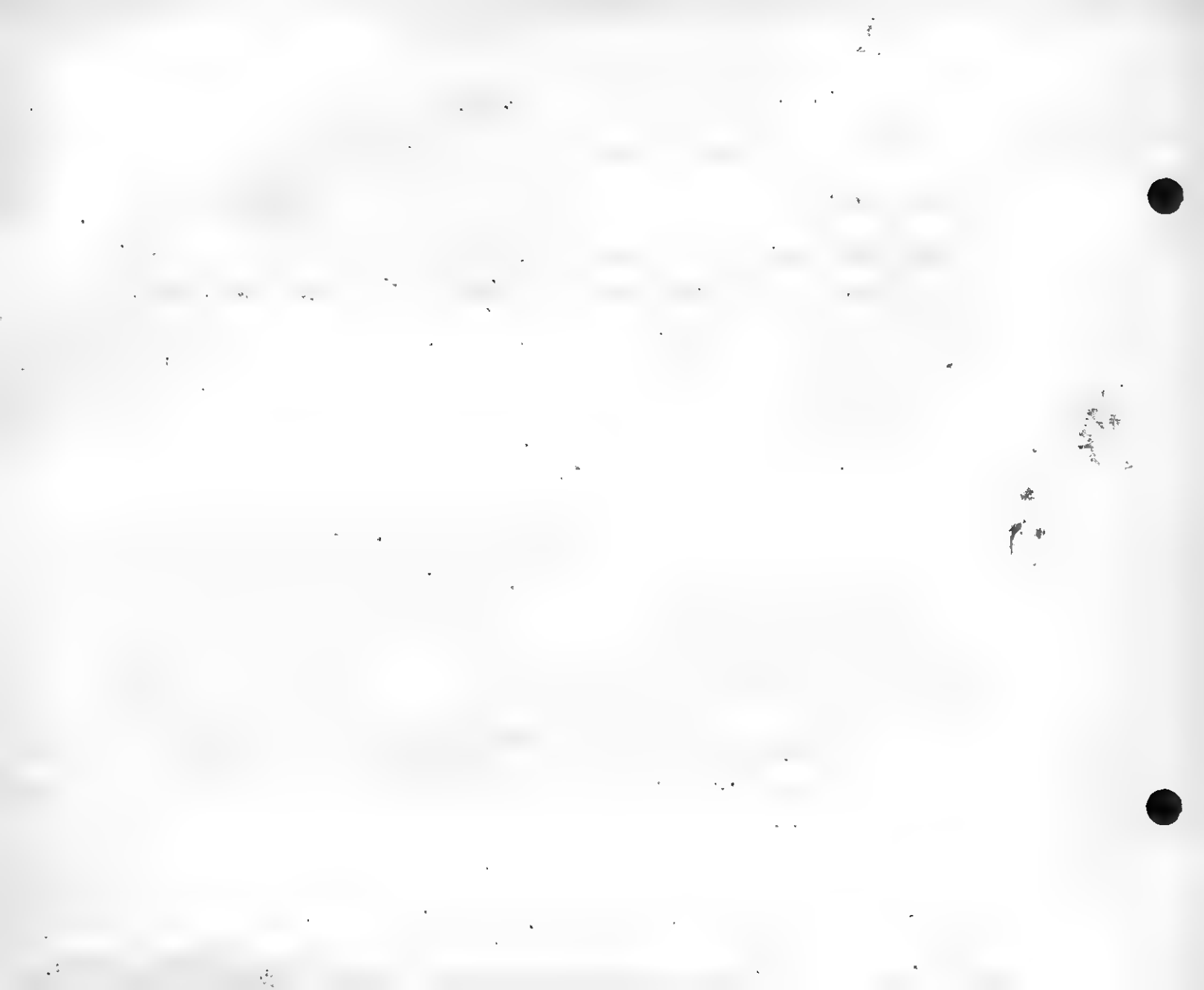
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 48 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1 DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year		2b. HOUR 75 ^{PM}	
ROBERT			GREEN			Month 7 Day 27 Year 68			
3 SEX		4 RACE		5. DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS	
Male		Caucasian		2/24/05		63 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH			
ENGLAND		U.S.A.				Montgomery Co.		Md.	
10. CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
Silver Spring			Holy Cross			TAXI DRIVER		TAXI	
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
Md.			Montgomery			Silver Spr		10506 Huntley Pl.	
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
SAMUEL			GREEN			RACHAEL		MISTY	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.			17 INFORMANT		Address	
No			579-44-659			FLORENCE GREEN - HUNTLEY PL - SIL SPR		10506 170	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									
PART I. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) _____									
DUE TO, OR AS A CONSEQUENCE OF _____									
(b) _____									
DUE TO, OR AS A CONSEQUENCE OF _____									
(c) _____									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
446X Diabetes Mellitus									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
				YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory) (Office building, etc.)		21f. LOCATION		Street or R.F.D. No.		City or Town County State	
22a. I certify that (I) (this doctor) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		DEGREE		ATTENDING PHYS.		<input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS.		22c. DATE SIGNED	
MICHAEL R. DORRIDGE, MD								July 18, 1968	
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS		22f. REGISTRAR'S SIGNATURE					
		17600 PARKLAND DR. ROCKVILLE, MD.		J. Charles Judge					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County) (State)	
BURIAL		7/29/68		GEO. WASH. CEM.		HYATTSVILLE		MD	
24 FUNERAL DIRECTOR		24b. ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Goldberg Funeral Home		4217 9th St. NW WASHINGTON, D.C. 20011		DATE JUL 31 1968					



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
Item 1, File 103 7/3 MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1 DECEASED NAME (Type or Print)			First Middle Last			2a DATE KNOWN OF DEATH ESTIMATED			2b HOUR		
Charles Clarence Greer						Month Day Year 7 8 1968			1:00 PM		
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR		F UNDER 24 HRS		2c DATE PRONOUNCED DEAD		2d HOUR	
M.	W.	9/15/12	35 YRS.	MONTHS	DAYS	HOURS	MIN.	Month Day Year 6/14 8 1968	1:00 PM		
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH			Md.		
Ohio		U.S.A.				Montgomery					
10. CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY		
Potomac			10700 River Rd			Laborer			Fencing		
13a USUAL RESIDENCE (Where deceased lived, if not in hospital admission) STATE			13b. COUNTY			13c CITY OR TOWN			13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
D.C.						Washington			1682 Irving Street N.W.		
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME								
Charles GREER			Martha								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SECURITY NO.			17 INFORMANT			ADDRESS		
						Son Robert L.			2349 Bell St Sacramento, California		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))											
PART 1. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) Myocardial Infarction recent + Remote											
DUE TO, OR AS A CONSEQUENCE OF											
(b) Coronary Arteriosclerosis thrombotic											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
42											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19				21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE John B. Ball				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b DATE SIGNED 8 July 68			
EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>							
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
				ADDRESS (Street, city, town, or county)							
23a BURIAL CREMATION, REMOVAL (Specify)			23b DATE		23c NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)			
Burial			July 13, 1968		Union Port			Union Port Ohio			
24 FUNERAL DIRECTOR Howard County Funeral Home of Harry H Witzke						ADDRESS Ellicott City Maryland		25a REC'D BY REGISTRAR JUL 16 1968		25b REGISTRAR'S SIGNATURE Charles Judge	

10210

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

2210

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in item 18. Give Pages 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with forms PH-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 DECEASED NAME (Type or Print)		First	Middle	Last		2a DATE KNOWN OF DEATH		Month	Day	Year	2b HOUR
Carroll		J.	Greenfell	Greenfell		2a DATE KNOWN OF DEATH		Month	Day	Year	2b HOUR
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	7 MONTHS	8 DAYS	9 HOURS	10 MIN	2c DATE PRONOUNCED DEAD		Month	Day
male	white	May 3, 1899	68					2c DATE PRONOUNCED DEAD		Month	Day
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH					
Washington, D.C.		U.S.A.				Montgomery					
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY					
Bethesda		Suburban		Superintendent, Dist. Govt.							
13a USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) STATE		13b CO. CITY		13c CITY OR TOWN		13d INSIDE CITY (Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		13e STREET AND NUMBER			
Md.		Mont. Co.		Bethesda		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		4817 - Chevy Chase			
14 FATHER'S NAME		15 MOTHER'S MAIDEN NAME		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b SOCIAL SECURITY NO		17 INFORMANT			
Frederick Greenfell		Luella Gardner		yes				Carroll F. Greenfell			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		19		20		21		22			
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		Cerebral Thrombosis Acute									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b) Arterio Sclerosis								years	
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c)											
332											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?			
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
22b. DATE SIGNED				22c. DATE SIGNED				22d. DATE SIGNED			
July 17, 1968				July 17, 1968				July 17, 1968			
23a. BURIAL CREMATION, REMOVAL (Specify)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY			
Burial				7-20-1968				Cedar Hill Cemetery			
23d. LOCATION (City or Town) (County) (State)				23e. REC'D BY REG. STRAR				23f. REGISTRAR'S SIGNATURE			
Suitland, Prince Georges Co., Md.				DATE JUL 22 1968				J. Charles Judge			
24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc., 5130 Wisc. Ave. N.W., Wash., D.C., 20016											



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30A REV 1-68

MARYLAND STATE DEPT. OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Mildred	Middle Louise	Last Grigsby	2a. DATE OF DEATH Month Day Year July 20 1968			2b. HOUR 6:55 PM
3 SEX Female		4. RACE Negro		5. DATE OF BIRTH 10 August 1907		6 AGE (n years last birthday) 60 YRS.		7 UNDER 1 YEAR MONTHS DAYS	8 UNDER 24 HRS HOURS MIN
7a BIRTHPLACE (State or foreign country) Alabama		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Montgomery Md.			
10 CITY OR TOWN OF DEATH Bethesda		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) The Clinical Center		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Clerk		12b KIND OF BUSINESS OR INDUSTRY ---			
13a USUAL RESIDENCE (Where deceased lived, if admission) STATE District of Columbia		13b COUNTY Washington		13c CITY OR TOWN Washington		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 4014 Meade Street, N.E.	
14 FATHER'S NAME First Middle Last Wash --- Grigsby		15 MOTHER'S MAIDEN NAME First Middle Last Carrie --- Fleming							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		(If yes give war or dates of service)		16b SOCIAL SECURITY NO Not available		17. INFORMANT The Medical Records, The Clinical Center, Bethesda, Maryland 20014			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Right middle lobe & right lower lobe pneumonia</u>									1 day
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Agranulocytosis</u>									1 month
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Felty's syndrome</u>									1 year
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC)		21f LOCATION Street or R.F.D. No		City or Town		County State	
22a. I certify that (X) (this hospital) attended the deceased from <u>24 June</u> , 19 <u>68</u> , to <u>20 July</u> , 19 <u>68</u> , that (X) (we) last saw the deceased alive on <u>20 July</u> , 19 <u>68</u> , and that in <u>my</u> (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death									
22b SIGNATURE <u>Philip W. Askenase, M.D.</u> MD DEGREE				ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED 20 July 1968			
22d. PHYSICIAN'S NAME (Type) Philip W. Askenase, M.D.				22e ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md. 20014					
23a BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b DATE 7-24-68		23c NAME OF CEMETERY OR CREMATORY LINCOLN MEMORIAL		23d LOCATION (City or Town)		(County) (State) SUITLAND, MD.	
24 FUNERAL DIRECTOR <u>Rafaelino Armenta</u>		ADDRESS 4339 N. ...		25a REC'D BY REG STRAR JUL 23 1968		25b REGISTRAR'S SIGNATURE <u>Charles J. ...</u>			



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

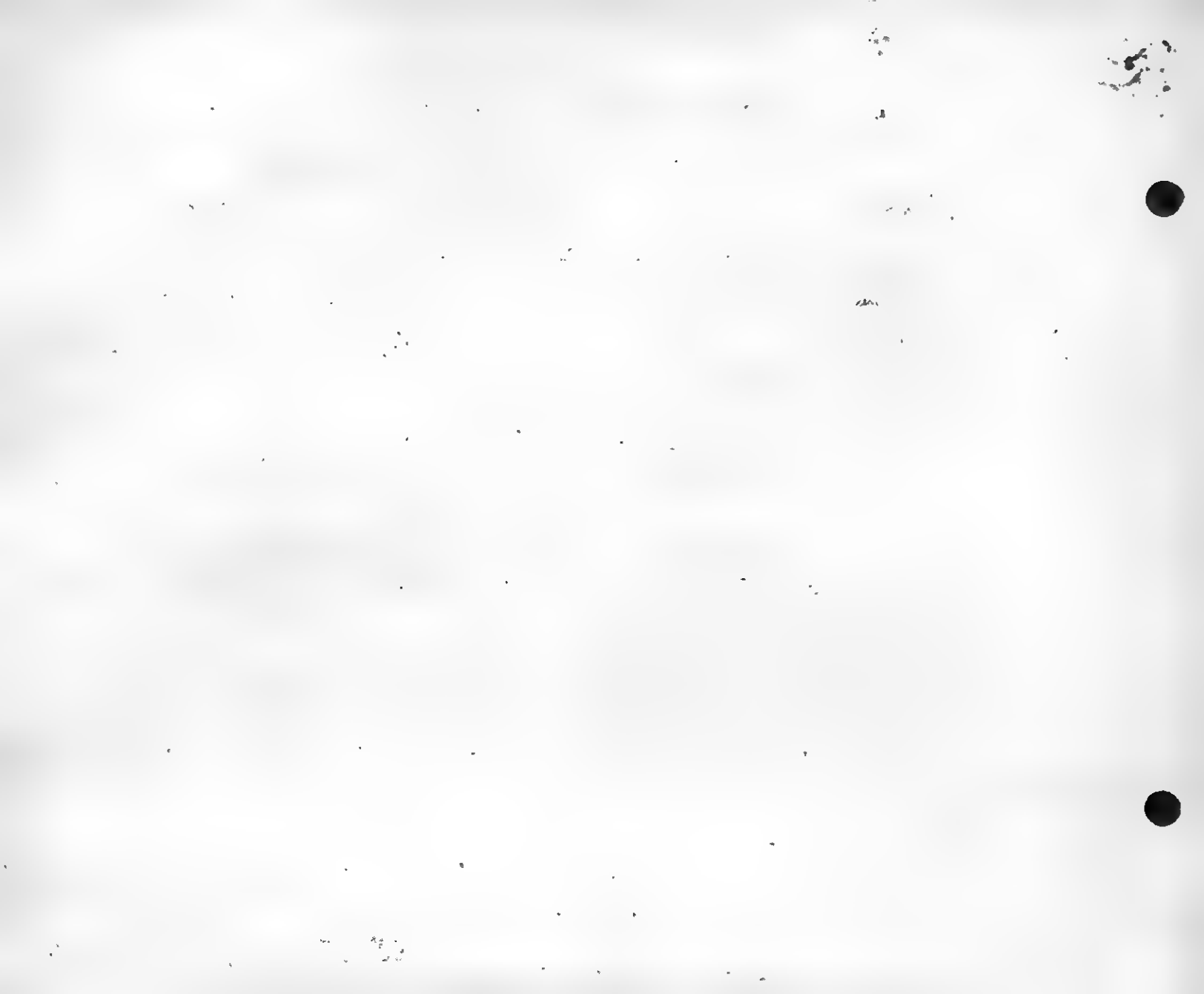
19212 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										10222		
MEDICAL EXAMINER'S CERTIFICATE OF DEATH												
1 DECEASED-NAME (Type or Print) Ella			First Mahe			Middle Hagerty			Last			
3 SEX Fe		4 RACE W.		5 DATE OF BIRTH 8-10-1878		6 AGE (in years last birthday) 89 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		
7a BIRTHPLACE (State or foreign country) MICHIGAN			7b CITIZEN OF WHAT COUNTRY? U.S.A.			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Montgomery			
10 CITY OR TOWN OF DEATH Potomac				11 NAME OF HOSPITAL OR INSTITUTION (If not a hospital give street address) 9924 Carmelita Drive				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HOUSEWIFE			12b KIND OF BUSINESS OR INDUSTRY	
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.				13b COUNTY Montgomery				13c CITY OR TOWN Potomac		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME First ROGER Middle MAHER Last MAHER				15. MOTHER'S MAIDEN NAME First MARY Middle MAHER Last MAHER								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO				16b SOCIAL SECURITY NO 575-66-6554				17 INFORMANT ADDRESS THOMAS A. GOWLING, NEPHEW, SAME AS 13c.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Insufficiency DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Coronary Arteriosclerosis-Suave DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Hours Years		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c) Generalized Arteriosclerosis												
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b TIME OF INJURY Month Day, Year HOUR A.M. 19 P.M.				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18)				
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f LOCATION Street or R.F.D. No City or Town County State				
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE John G. Ball				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b DATE SIGNED July 10, 1968				
EXAMINER'S NAME (Type) John G. Ball				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
				ADDRESS (Street, city, town, or county)								
23a BURIAL, CREMATION, REMOVAL (Specify) Cremation				23b DATE 7-11-1968				23c NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory				
23d LOCATION (City or Town) Suitland				23e (County) Prince Georges				23f (State) Md.				
24 FUNERAL DIRECTOR Joseph Gawler's Sons, Inc., 5130 Wisc. Ave. N.W., Wash., D.C., 20016				25a REC'D BY REGISTRAR JUL 15 1968				25b REGISTRAR'S SIGNATURE Charles Judge				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH												
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
CERTIFICATE OF DEATH												
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR			
Leolyn May Halloran						7 Month 12 Day 68			7:45 a M			
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
Female		White		1-10-03			65 YRS.		MONTHS DAYS		HOURS M.N.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH					
Kansas		U.S.A.					Montgomery Md					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired)			12b. KIND OF BUSINESS OR INDUSTRY			
Takoma Park			Washington Sen. + Hosp			Homemaker			Own Home			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER		
Maryland			P.G.			Mt. Rainier		YES		3203 Queenstown Dr Apt 101		
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last									
Albert - Peterson			Mary - Swain									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)			16b. SOCIAL SECURITY NO			17. INFORMANT Address						
No						Hospital Records						
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) ACUTE PERITONITIS WITH PERFORATION										24-48 Hrs		
441.9 DUE TO, OR AS A CONSEQUENCE OF (b) GANGRENE OF SIGMOID COLON										24-48 Hrs		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) DISTAL AORTIC ANEURYSM OCCLUSION												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
SEVERE GENERALIZED ARTERIOSCLEROSIS - DIABETES MELLITUS												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
		19										
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State		
22a. I certify that (I) (this hospital) attended the deceased from October 1967, to July 12, 1968, that (I) (we) last saw the deceased alive on July 11, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE						DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED		
ROBERT B. IREY										7-12-68		
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS						
ROBERT B. IREY						11161 New Hampshire Ave. Silver Spring Md						
23a. BURIAL, CREMATION (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)		
Burial		7/15/68		Baltimore National		Baltimore		Baltimore		Md.		
24. FUNERAL DIRECTOR ADDRESS						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
Harris Funeral Home Hyattsville, Md						JUL 17 1968		Charles Judge				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

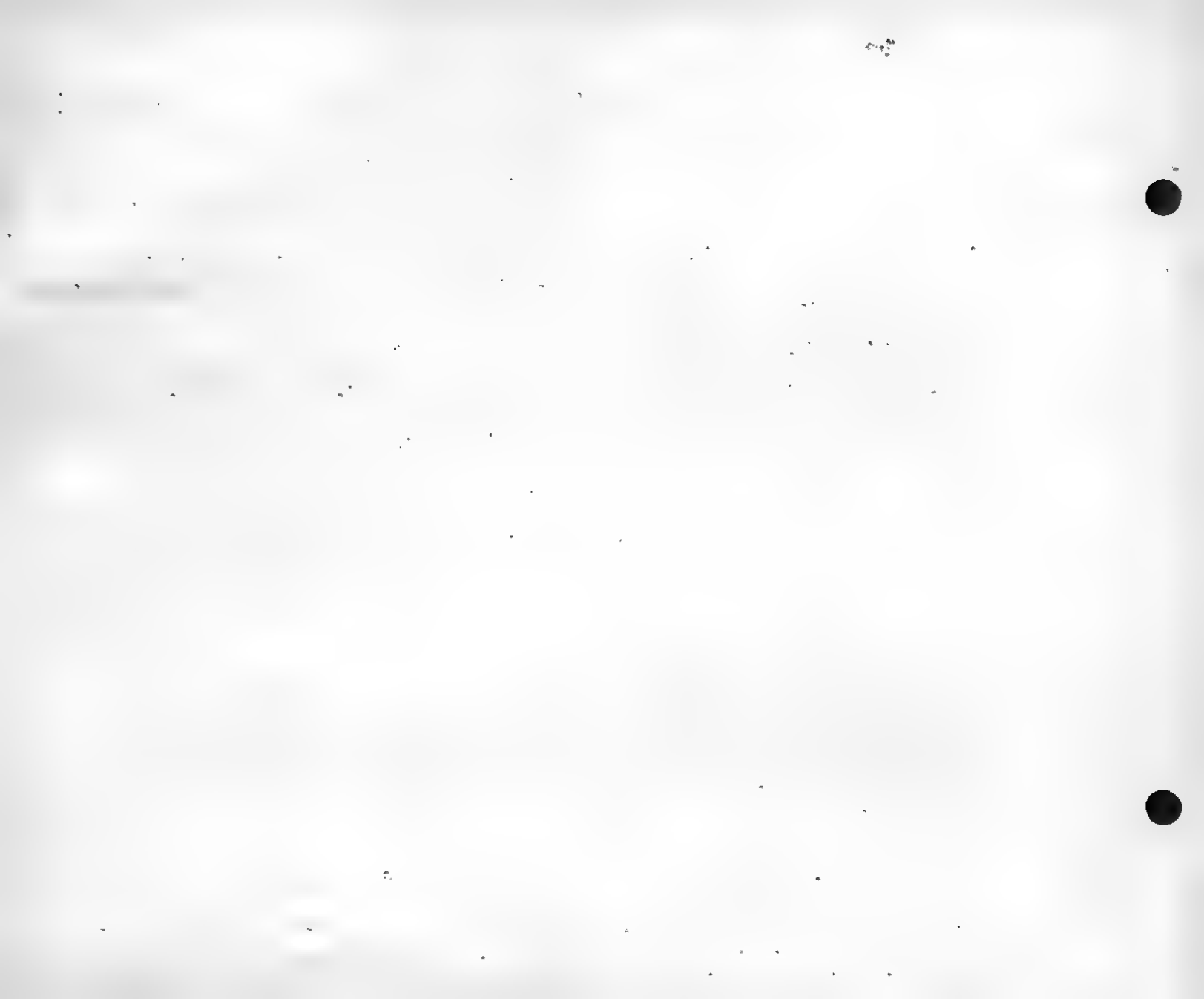
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10214

CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) ^{First} William ^{Middle} Henry ^{Last} Halstead			2a DATE OF DEATH July Month 6 Day 1968			2b HOUR 4:25 PM	
3 SEX M		4 RACE W		5 DATE OF BIRTH 10-16-94		6 AGE (In years last birthday) 73 YRS	
7a BIRTHPLACE (State or foreign country) N. J.		7b. CITIZEN OF WHAT COUNTRY? U.S.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Montgomery County Md	
10. CITY OR TOWN OF DEATH Silver Spring		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Holy Cross Hosp		12a USJA. OCCUPATION (Kind of work done during most of working life, even if retired.) Retired		12b. KIND OF BUSINESS OR INDUSTRY Army	
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.		13b COUNTY Montgomery		13c CITY OR TOWN Silver Spring		13d INSIDE CITY LIMITS? NO	
				13e STREET AND NUMBER 408 Lamberton Dr		13f CROSS STREET Guthrie Blvd	
14. FATHER'S NAME First Middle Last Henry W. Halstead				15. MOTHER'S MAIDEN NAME First Middle Last Cona Ruth Morton			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown yes		16b SOCIAL SECURITY NO. 114-1		17 INFORMANT Howard Kirk		Address Silver Spring, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Anteroseptal Myocardial Infarction</u> 7109 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary Artery Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <u>Arteriosclerosis</u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12 hours years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 1968		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f LOCATION Street or R.F.D. No City or Town County State			
22a I certify that (I) (this hospital) attended the deceased from 7/5, 1968, to 7/6, 1968, that (I) (we) lost the deceased alive on 7/6, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Dr. Leonard Gold				DEGREE MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 7/6/68	
22d PHYSICIAN'S NAME (Type) Dr. Leonard Gold				22e. ADDRESS 9801 Georgia Avenue			
23a BURIAL CREMATION, REMOVAL (Specify)		23b DATE July 10, 1968		23c. NAME OF CEMETERY OR CREMATORY St. Lincoln Crematory		23d LOCATION (City or Town) (County) (State) Prince George Co., Md.	
24. FUNERAL DIRECTOR Warner E. Pimpney, Inc. Silver Spring, Md.				25a REC'D BY REG STRAR JUL 10 1968		25b REGISTRAR'S SIGNATURE Charles J. J...	



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-1. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201													
MEDICAL EXAMINER'S CERTIFICATE OF DEATH													
1. DECEASED NAME (Type or Print) <i>Francis L. Harding</i>			First Middle Last			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <i>July</i> Day <i>1</i> Year <i>1968</i>			2b. HOUR <i>10:30</i> M				
3. SEX <i>male</i>		4. RACE <i>white</i>		5. DATE OF BIRTH <i>11-15-1911</i>		6. AGE (in years last birthday) <i>56</i> YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN			
7a. BIRTHPLACE (State or foreign country) <i>Iowa</i>			7b. CITIZENSHIP WHAT COUNTRY? <i>USA</i>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <i>Montgomery</i> Md				
10. CITY OR TOWN OF DEATH <i>Baltimore</i>				11. NAME OF HOSPITAL OR INSTITUTION (If not a hospital give street address) <i>Summit Lane</i>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Builder</i>				12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE <i>Maryland</i>				13b. COUNTY <i>Montgomery</i>				13c. CITY OR TOWN <i>Baltimore</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <i>Greenhill Road</i>	
14. FATHER'S NAME <i>Earle H. Harding</i> First Middle Last						15. MOTHER'S MAIDEN NAME <i>Effie LaVerne</i> First Middle Last							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>Yes.</i>				16b. SOCIAL SECURITY NO <i>Unknown</i>		17. INFORMANT <i>Wife</i> ADDRESS <i>Same as Item 13.</i>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))													
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Acute Coronary Thrombosis</i>													
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Cardiovascular Disease</i>													
DUE TO, OR AS A CONSEQUENCE OF (c) <i>4109</i>													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
4													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. <i>19</i>				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE <i>John G. Ball</i>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED <i>1 July 68</i>					
EXAMINER'S NAME (Type) <i>JOHN G. BALL</i>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>									
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>									
				ADDRESS (Street, city, town, or county) <i>Bethesda, Md.</i>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>				23b. DATE <i>7-3-68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Parklawn Cemetery</i>				23d. LOCATION (City or Town) (County) (State) <i>Rockville, Maryland</i>			
24. FUNERAL DIRECTOR <i>ROBERT A. PUMPHREY, Bethesda, Maryland</i>						25a. REC'D BY REGISTRAR <i>JUL - 5 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

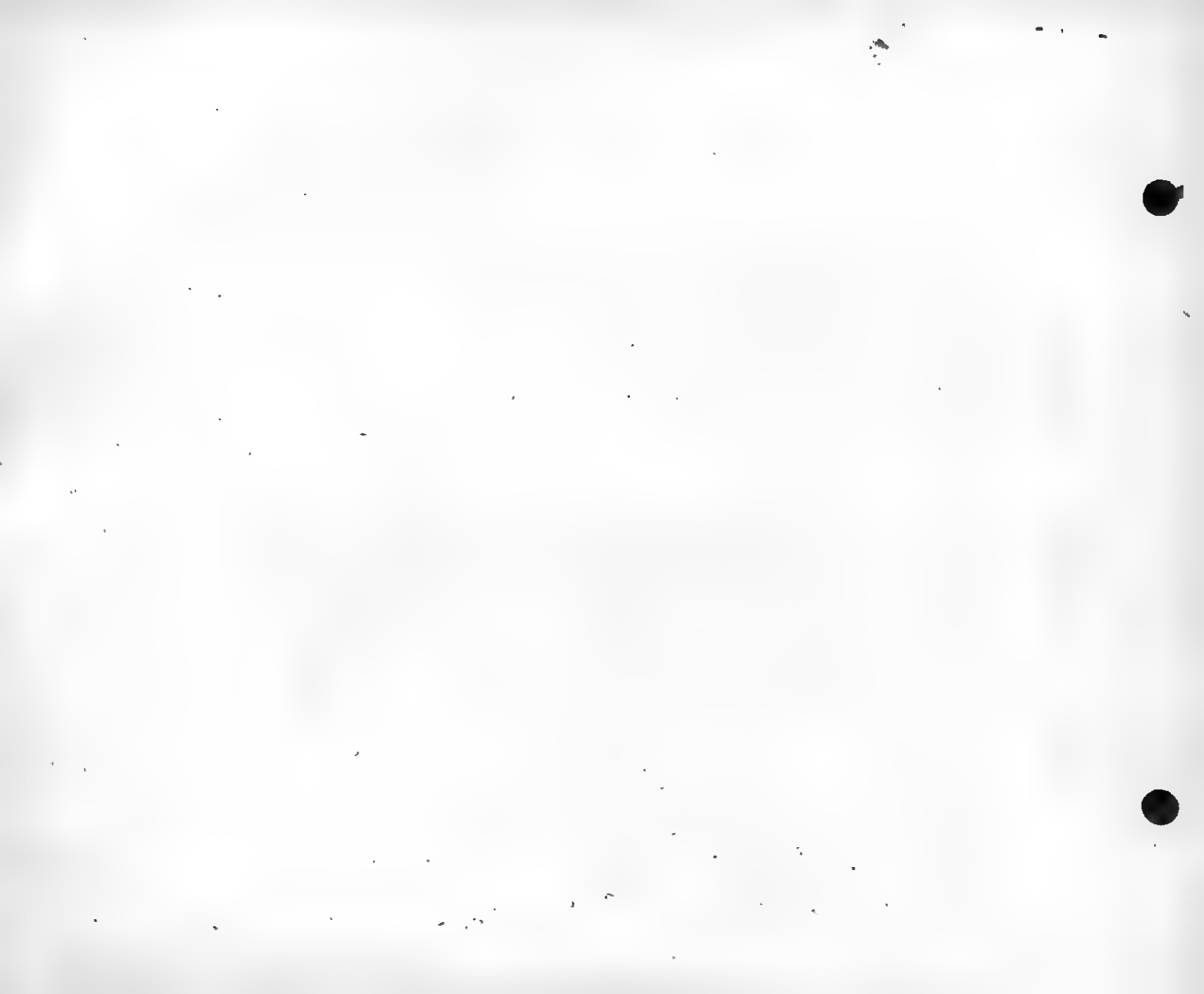
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or Print)			First	Middle	Last	2a. DATE KNOWN OF DEATH		2b. HOUR	
Linda Ann Hardy						ESTIMATED <input checked="" type="checkbox"/> 7-4 1968		10:15 PM	
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS		2c. DATE PRONOUNCED DEAD	
Female	Negro	4/29/50	18 YRS	MONTHS	DAYS	HOURS	MIN	Month July Day 4 Year 1968	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Maryland		USA				Montgomery Md			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
Bethesda			Suburban			Henderson Program		Shawwood Elem. School	
13a. USLA. RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Md.			Montgomery			Sandy Spring		Brook Road	
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle Last
James Hardy						Edna Williams			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes and, or unknown)			16b. SOCIAL SECURITY NO			17. INFORMANT		ADDRESS	
No									
18. CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c))									APPROX. MATE. INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) <u>Transection cervical spinal cord</u>									<u>Sudden</u>
DUE TO, OR AS A CONSEQUENCE OF <u>Fracture cervical vertebrae</u>									<u>Sudden</u>
(b) <u>Motorcycle accident</u>									
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
7154									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>			21b. TIME OF INJURY Month, Day, Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
10:15 PM			7/4 1968		Postmortem on motorcycle collided with auto				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No City or Town County State				
			Highway		Embry Grove Rd. Gaithersburg Montgomery				
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE			EXAMINER'S NAME (Type)			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED	
John B. Ball						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		5 July 68	
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
						ADDRESS (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
BURIAL		7-8-68		Browns Chapel		Dayton, Howard, Md.			
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Robert L. Snowden			Rockville			JUL 10 1968		Charles J. J. J.	

CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) ARTHUR J. HARNETT			2a. DATE OF DEATH Month 7 - Day 28 - Year 68			2b. HOUR 10 P M	
3 SEX M		4 RACE W		5 DATE OF BIRTH 7-13-1890		6 AGE (In years last birthday) 78 YRS.	
7a. BIRTHPLACE (State or foreign country) ENGLAND		7b. CITIZEN OF WHAT COUNTRY? USA.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH MONTGOMERY Md.	
10 CITY OR TOWN OF DEATH WHEATON MD		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) KENSINGTON GARDENS SAN. HOTEL MANAGER		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE D.C.		13b. COUNTY WASHINGTON NW		13c. CITY OR TOWN WASHINGTON NW		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 1549 35th ST.		13f. CITY OR TOWN APT I		13g. STREET AND NUMBER APT I		13h. CITY OR TOWN APT I	
14. FATHER'S NAME First DAVID - Middle HARNETT Last GRACE			15. MOTHER'S MAIDEN NAME First MARY - Middle GRACE Last GRACE				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No (If yes give war or dates of service)		16b. SOCIAL SECURITY NO 577-10-0396A		17. INFORMANT DR. DAVID A HARNETT Address 47 Cambridge Mass			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 4107 DUE TO, OR AS A CONSEQUENCE OF ASCVD Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last CA of Lung, & h of CVA (b) ASCVD (c) CA of Lung, & h of CVA APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes years years							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4107							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 1956 to July , 1968, that (I) (we) last saw the deceased alive on 7/21/1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE W. LOBB MOON				22c. DATE SIGNED 7/28/68			
22d. PHYSICIAN'S NAME (Type) W LOBB MOON				22e. ADDRESS 2001 I St NW Wash D.C.			
23a. BURIAL CREMATION, REMOVAL (Specify)		23b. DATE 7-31-68		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cem.		23d. LOCATION (City or Town) (County) (State) Wheaton Md.	
24. FUNERAL DIRECTOR W.W. Chambers C				25a. REC'D BY REGISTRAR 3072-M-18 MD		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

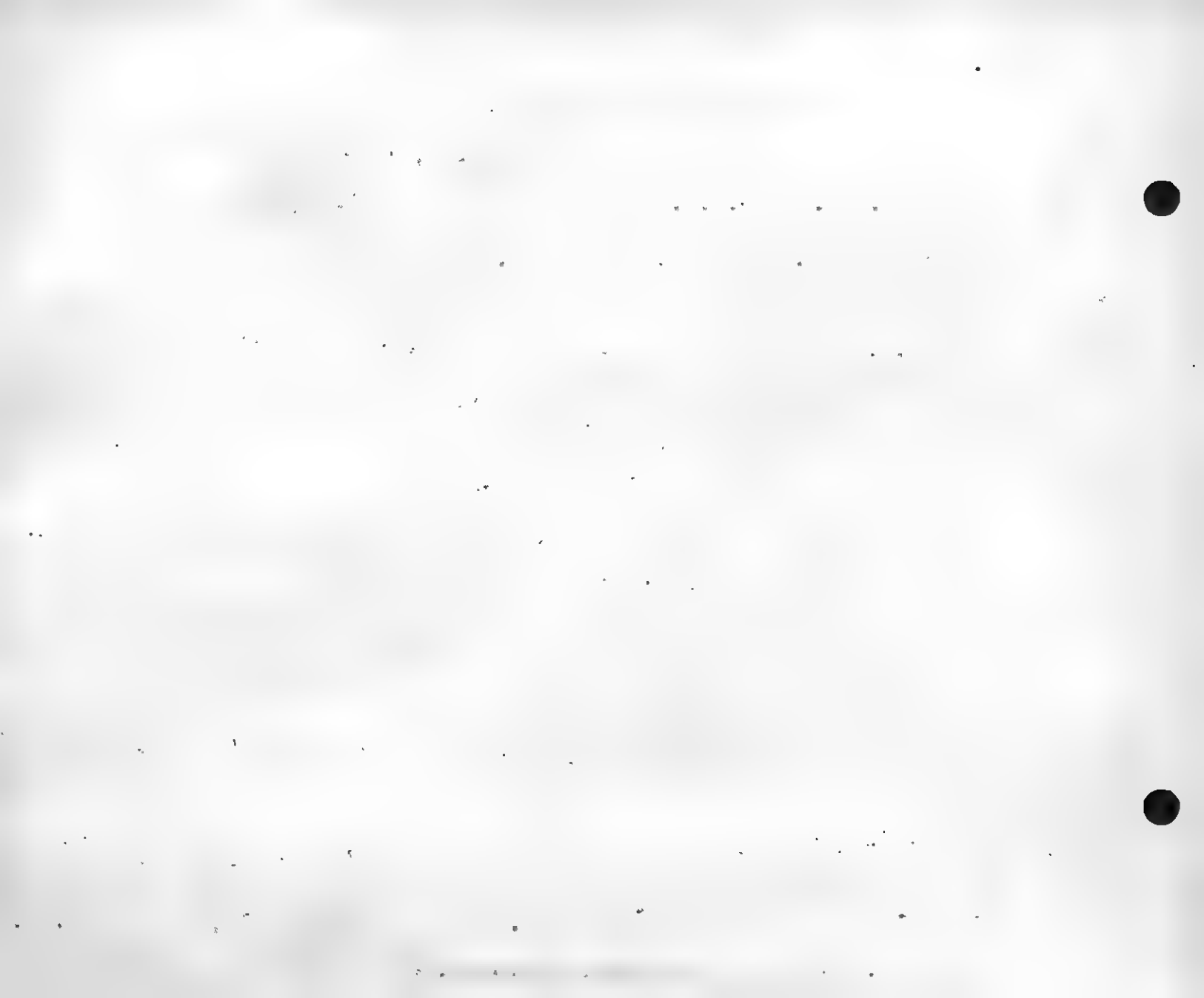
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and, in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1 DECEASED-NAME (Type or print)			First Middle Last			2a DATE OF DEATH			2b HOUR
Virginia Roberta Harper						Month 7 Day 6 Year 68			6:45 AM
3. SEX		4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.
Female		White		Feb. 5, 1879		89 YRS.		5 1	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
West. Va.		U.S.A.				Montgomery Md			
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY	
Kensington Md.			Carroll Hall San.			Housewife			
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE			13b COUNTY		13c CITY OR TOWN	13d INSIDE CITY (Y or N)	13e STREET AND NUMBER		
West Virginia					Morefield	YES <input type="checkbox"/> NO <input type="checkbox"/>	c/o Mrs. Thelma Harper		
14 FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
J.D. Christian			Rebecca Rinick						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)			16b. SOCIAL SECURITY NO.		17 INFORMANT Address				
					Hospital Record				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Congestive Failure</u> <u>4125</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arterio-sclerotic Heart Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Coronary atherosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u> <u>years</u> <u>years</u>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Chronic vascular insufficiency</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>June 1, 1968</u> to <u>July 6, 1968</u> , that (I) (we) last saw the deceased alive on <u>July 5, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		DEGREE		ATTENDING PHYS.		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED	
<u>George Thayer</u>		M.D.		<input checked="" type="checkbox"/>				7/6/68	
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS							
George Thayer		10400 Connecticut Ave Kensington, Md							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		7/8/68		Olivet Cem.		Moorefield, W. Va.			
24. FUNERAL DIRECTOR		25a. REGISTRY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Robert A. Pumphrey		7557 Wisc. Ave. Beth. Md.		JAN 23 1969					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 12 hours after death.

VR A15 M
30M REV. 7/68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201														
CERTIFICATE OF DEATH														
1 DECEASED-NAME (Type or print)						2a. DATE OF DEATH			2b. HOUR					
First Middle Last Alma H. HARVEY						Month Day Year 7-23-68			9 ⁵⁵ A M					
3. SEX		4 RACE		5. DATE OF BIRTH			6 AGE (In years post birth day)		7 UNDER 1 YEAR		8 UNDER 24 HRS			
FEMALE		White		6-4-03			65 ⁶⁴ YRS.		MONTHS DAYS		HOURS MIN.			
7a BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH					
D.C.			U. S. A.						Montgomery County, Md					
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USJA. OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY					
Silver Spring, Md.			Holy Cross			Clerk typist - Retired Gov't.								
13a USJA. RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b COUNTY			13c CITY OR TOWN			13d INSIDE CITY LIMITS?			13e STREET AND NUMBER		
Md.			Montgomery			Silver Spring			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			8710 PLYMOUTH STREET		
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME											
First Middle Last Samuel L. Phillips			First Middle Last Anita Behrens											
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or (unknown) No			16b SOCIAL SECURITY NO. 577-60-1375			17 INFORMANT			Address: 8706 Reading Road Silver Spring, Md.					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)														
PART I. DEATH WAS CAUSED BY:														
IMMEDIATE CAUSE (a) Bleeding esophageal varices														
71.9 DUE TO, OR AS A CONSEQUENCE OF														
(b) Cirrhosis of liver														
DUE TO, OR AS A CONSEQUENCE OF														
(c)														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)														
Metastatic breast carcinoma in pleura.														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>								
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b TIME OF INJURY			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
			HOUR A.M. Month Day Year P.M. 19											
21d. INJURY OCCURRED			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION			City or Town County State					
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>						Street or R.F.D. No								
22a. I certify that (I) (this hospital) attended the deceased from 1966, to 7/23, 1968, that (I) (we) last saw the deceased alive on 7/22, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														
22b SIGNATURE						DEGREE			22c DATE SIGNED					
William D. Aud M.D.									7/24/68					
22d PHYSICIAN'S NAME (Type)						22e ADDRESS								
WILLIAM D. AUD, M.D.						9006 Colesville Rd., S.S., Md.								
23a BURIAL, CREMATION, REMOVAL (Specify)			23b DATE			23c NAME OF CEMETERY OR CREMATORY			23d LOCATION (City or Town) (County) (State)					
Burial			July 27, 1968			Gate of Heaven Cemetery			Silver Spring, Md.					
24 FUNERAL DIRECTOR			ADDRESS			25a REC'D BY REGISTRAR			25b REGISTRAR'S SIGNATURE					
Warner E. Pumphrey, Inc.			8434 Georgia Ave. Silver Spring, Md.			JUL 31 1968			Charles Judge					

MEDICAL CERTIFICATION



20219

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1, 2, and 3 with the State Department of Health prior to burial, cremation, or removal and in any event within 72 hours after death.

1. DECEASED-NAME (Type or Print)		First	Middle	Last	2a. DATE KNOWN OF DEATH		<input checked="" type="checkbox"/> Month	Day	Year	2b. HOUR
George A. Bert		Head.			JULY 29 1968					10:15 PM
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR	7. DATE PRONOUNCED DEAD		Month	Day	Year	2d. HOUR
M.	N.	NOV 28 1926	41 YRS	MONTHS DAYS HOURS MIN.	JULY 29 1968					10:15 PM
7a. BIRTH-PLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Bethesda.		U.S.A.				Montgomery		Md		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. U.S.A. OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY				
Bethesda.		Suburban.		Foreman U.S. Post Office		U.S. Post Office				
13a. U.S.A. RESIDENCE (Where deceased lived, if institution residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET AND NUMBER		
Florida				Tampa.				3119 De Leon St. apt #4		
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle	Last	
UNKNOWN					UNKNOWN					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS				
NO		262-26-3267		Hosp Records						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary thrombosis, left</u>										1 hour
4107 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Advanced coronary arteriosclerosis</u>										years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c)										
4201										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
		HOUR A.M. P.M. 19								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE		John B. Ball		M.D.		22b. DATE SIGNED		30 July 68		
EXAMINER'S NAME (Type)		John B Ball								
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) State				
Burial		8-2-68		Myrtle Hill Cemetery Tampa		Hills Florida		Florida		
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
Robert A Pumphrey		7557 Wisconsin Ave Bethesda, Md		AUG 2 1968		Charles Judge				



1. TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

2. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED NAME (Type or print)		First Harry		Middle L.		Last Heckman		2a. DATE OF DEATH Month 7 Day 1 Year 68		2b. HOUR 4A M
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH 12-31-1888		6. AGE (in years last birthday) 79 YRS		IF UNDER 1 YEAR MONTHS DAYS 		IF UNDER 24 HRS HOURS MIN
7a. BIRTHPLACE (State or foreign country) Penna.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery		Md		
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 2600 Jennings Road				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Retired Accountant		12b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't.		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Sp.		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 2600 Jennings Road		
14. FATHER'S NAME First Middle Last William A. Heckman				15. MOTHER'S MAIDEN NAME First Middle Last Sarah Louise Yost						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, (g), or (unknown) No (If yes, give war or dates of service)		16b. SOCIAL SECURITY NO 189-10-6364		17. INFORMANT Address Mrs. Mary C. Heckman, Widow - see #13						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary heart failure DUE TO, OR AS A CONSEQUENCE OF arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 yrs 10 yrs										
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 4										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State 4/15 7/1 1968 7/1 1968						
22a. I certify that (I) (this hospital) attended the deceased from 4/15 , 19 68 , to 7/1 , 19 68 , that (I) (we) lost saw the deceased alive on 7/1 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE [Signature]		22c. PHYSICIAN'S NAME (Type) Dr. F. Kreuzburg		22d. ADDRESS 2852 16th Ave NW Wash Dc		22e. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22f. DATE SIGNED 7/1/68		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 7-3-1968		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		23d. LOCATION (City or Town) (County) (State) Bladensburg, Prince Georges, Md.				
24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc., 5130 Wisc. Ave. N.W., Wash., D.C., 20016				25a. RECD BY REGISTRAR DATE JUL - 5 1968		25b. REGISTRAR'S SIGNATURE [Signature]				



FOR STATE HEALTH DEPT.

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100221

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

100231

1 DECEASED NAME (Type or Print)			First Middle Last			2a DATE KNOWN OF DEATH Month Day Year			2b HOUR		
FRANK C. HEISS						7 29 1968			12:10 P.M.		
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years, months, days)	IF UNDER 1 YEAR	IF UNDER 24 HRS	2c. DATE PRONOUNCED DEAD Month Day Year			2d HOUR		
Male	White	Oct. 28, 1889	78 YRS	X	X	7 Day 29 Year 19			12:10 P.M.		
7a BIRTHPLACE (State or foreign)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH					
New York		U.S.A.				Montgomery Md					
10. CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY		
Silver Spring, Montgomery			Wash San & Hosp.			Ret. Asst. Gen. Asst. Agr.					
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE				13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY, M.D.? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER	
Maryland				Montgomery		Silver Sp.		YES <input type="checkbox"/> NO <input type="checkbox"/>		1560 East West Hgwy.	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last			ADDRESS					
Henry J. Heiss			Anna Wassler			Mrs. Anna M. Heiss 1560 E.W. Hgwy. S.S. Md.					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SECURITY NO.			17. INFORMANT					
Yes			579-60-0578			Mrs. Anna M. Heiss					
18. CAUSE OF DEATH (Enter any one cause per section (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Insufficiency</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Artery Heart Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Essential Hypertension</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18.)					
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f LOCATION Street or R.F.D. No			City or Town County State		
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE			M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED		
EXAMINER'S NAME (Type)			M.D.			ASSISTANT MED. CA. EXAMINER <input type="checkbox"/>			July 29, 1968		
Belden K. Heap			Belden K. Heap M.D.			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			Washington		
23a BURIAL, CREMATION, REMOVAL (Specify)			23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)				
Burial			Aug. 1, 1968		Rook Creek Cemetery		Washington D.C.				
24 FUNERAL DIRECTOR						25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE			
Warner E. Humphrey, Inc. 8434 Ga., Ave., S.S.						AUG 2 1968		Charles Judge			

FOR STATE HEALTH DEPT.

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19222

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or Print)			First	Middle	Lost	2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month Day Year			2b. HOUR
Laura						July 24 1968			1 PM
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (in years last birthday)	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD Month Day Year			2d. HOUR
Fe.	W.	9/7/1896	71 YRS			July 24 1968			1 PM
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Virginia		U.S.A.				Montgomery Md.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
Rockville		Potomac Valley Nursing Home		Housewife					
13a. USUAL RESIDENCE (Where deceased lived, if institution on admission) STATE		13b. COUNTY		13c. CITY OR TOWN		3d. INS. DE CITY - M. IS?		13e. STREET AND NUMBER	
Md.		Montgomery		Chevy Chase		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		3718 Manor Rd.	
14. FATHER'S NAME			First	Middle	Lost	15. MOTHER'S MAIDEN NAME			First Middle Lost
CHARLES						FANNY			KING
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOC. SEC. SECURITY NO.			17. INFORMANT			
No			-			EDWARD H. HELMUTH, HUSBAND, SAME AS #13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Brain Tumor Right Frontal Lobe.</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>31X</u> (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>7 years</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Cardio Vascular Disease - Diabetes Mellitus -</u>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion									
ACTUAL SIGNATURE <u>John S. Ball</u>			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county)			22b. DATE SIGNED <u>July 24, 1968</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)
Cremation			7-25-1968			Cedar Hill Crematory			Suitland, Prince Georges Md.
24. FUNERAL DIRECTOR <u>Joseph Gawler's Sons, Inc., 5130 Wisc. Ave. Wash., D.C., 20016</u>			25a. REC'D BY REGISTRAR DATE <u>JUL 26 1968</u>			25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

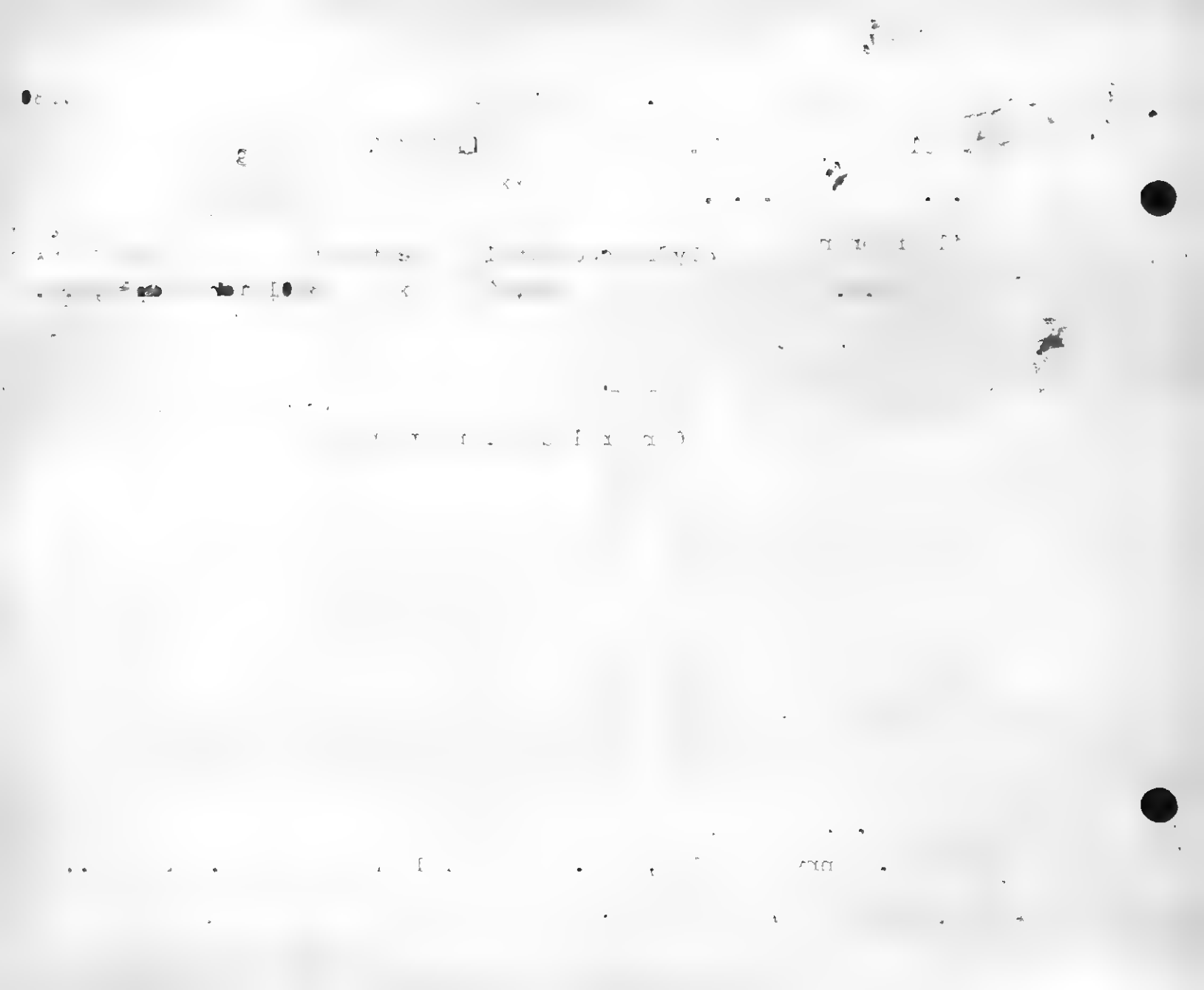


CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, removal, and in any event, within 72 hours after death.

1 DECEASED NAME (Type or print) ANDREW		Middle R.		Last HERBERT		2a. DATE OF DEATH Month 7 Day 21 Year 68 9:30 A	
3 SEX Male		4. RACE Wh.		5. DATE OF BIRTH 11/15/15		6 AGE (In years last birthday) 53 YRS	
7a BIRTHPLACE (State or foreign country) D.C.		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery	
10 CITY OR TOWN OF DEATH Silver Spring		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Holy Cross Hospital		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Meat Cutter		12b KIND OF BUSINESS OR INDUSTRY Wheaton SuperMarket	
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland		13b COUNTY Prince George's		13c CITY OR TOWN West		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME First Harold Middle Herbert Last Herbert		15. MOTHER'S MAIDEN NAME First Amy Middle Mattingly Last Mattingly		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, as, at unknown <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)		16b SOCIAL SECURITY NO 577-10-6942	
17. INFORMANT William E. Herbert - wife		Address Rockville, Md.		18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Hemorrhage DUE TO, OR AS A CONSEQUENCE OF (b) Stroke DUE TO, OR AS A CONSEQUENCE OF (c) Stroke		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 DAYS	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 331X Do not know							
19a. DATE OF OPERATION 7/21/68		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Do not know		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21b. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No City or Town County State			
22a I certify that (I) (this hospital) attended the deceased from 19 July, 1968 , to 21 July, 1968 , that (I) (we) lost saw the deceased alive on 21 July 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b SIGNATURE Henry R. Wolfe		DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c DATE SIGNED 7/21/68			
22d. PHYSICIAN'S NAME (Type) Henry R. Wolfe, M.D.		22e ADDRESS 1131 Univ. Blvd. W., Sil. Spr., Md.					
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE July 24, 1968		23c NAME OF CEMETERY OR CREMATORY Arlington National		23d LOCATION (City or Town) (County) (State) Arlington, Virginia	
24 FUNERAL DIRECTOR John Turner Home		ADDRESS 1911 Rock. Pike		25a. REG'D BY REGISTRAR JUL 23 1968		25b REGISTRAR'S SIGNATURE Charles Judge	



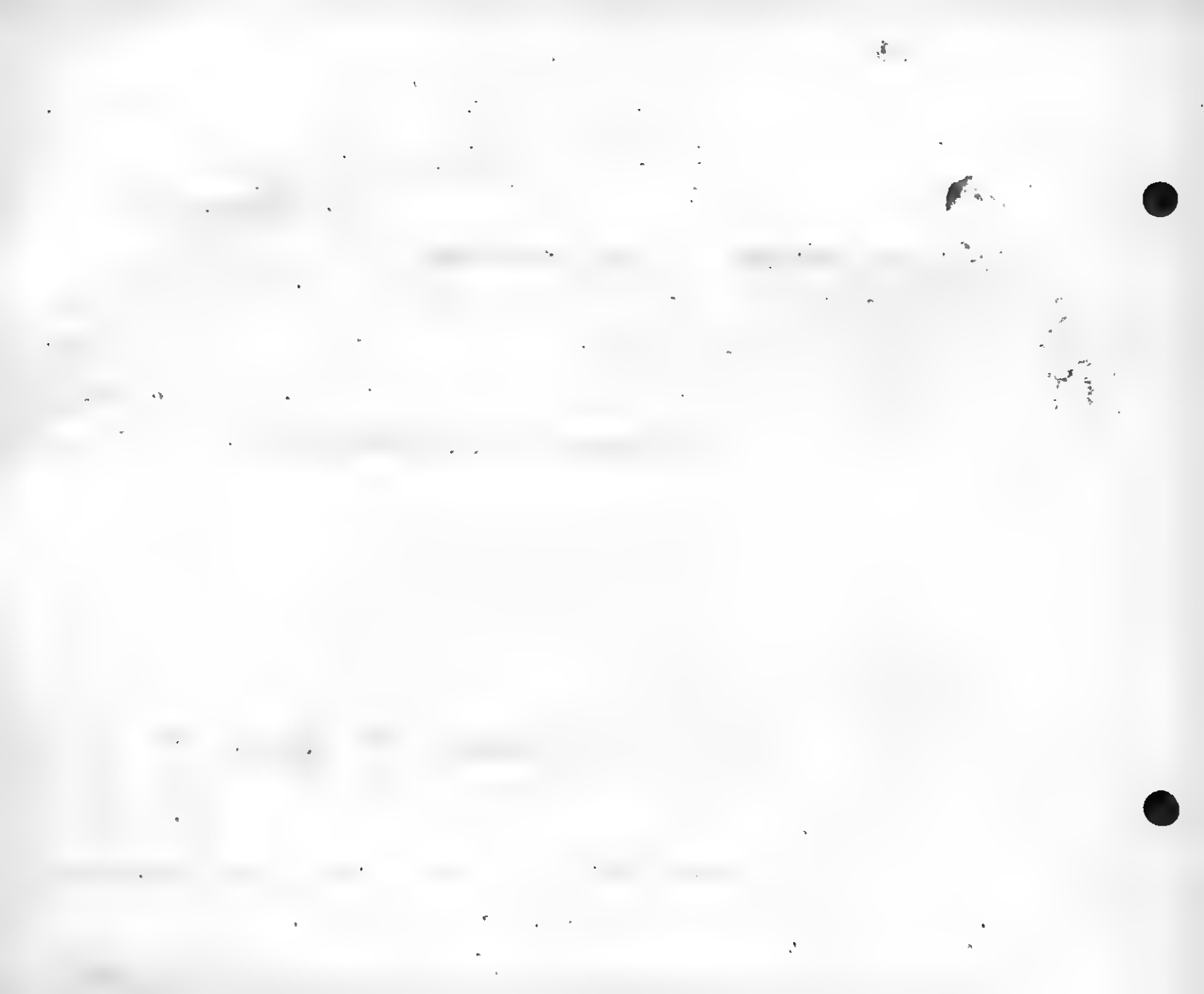
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) First <i>Katherine</i> Middle <i>C</i> Last <i>Herbert</i>			2a. DATE OF DEATH Month <i>7</i> Day <i>29</i> Year <i>68</i>			2b. HOUR <i>8:05 P</i>	
3. SEX <i>F</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>12/26/95</i>		6. AGE (In years last birthday) <i>72</i>	
7a. BIRTHPLACE (State or foreign country) <i>D.C.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i>	
10. CITY OR TOWN OF DEATH <i>Silver Spring</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Holy Cross Hosp</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Maryland</i>		13b. COUNTY <i>Montgomery</i>		13c. CITY OR TOWN <i>Kensington</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER <i>3514 Anderson Road</i>		14. FATHER'S NAME First <i>John</i> Middle <i>J</i> Last <i>Connor</i>		15. MOTHER'S MAIDEN NAME First <i>Catherine</i> Middle <i>McCarthy</i> Last <i>McCarthy</i>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i>	
16b. SOCIAL SECURITY NO <i>yes</i>		17. INFORMANT <i>Joseph R. Herbert, Sr.</i>		17b. ADDRESS <i>3514 Anderson Road Kensington, Md.</i>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Adenocarcinoma of Esophagus</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>3 years</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>17 years</i>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State		22a. I certify that (I) (this hospital) attended the deceased from <i>December 1965</i> , to <i>July 29, 1968</i> , that (I) (we) last saw the deceased alive on <i>July 29, 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.	
22b. SIGNATURE <i>Blaine H. Eig</i>		22c. DATE SIGNED <i>7/30/1968</i>		22d. PHYSICIAN'S NAME (Type) <i>BLAINE H. EIG</i>		22e. ADDRESS <i>9601 Georgia Ave. Silver Spring, Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>August 29, 1968</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Suitland Maryland</i>	
24. FUNERAL DIRECTOR <i>Warner E. Pumphrey, Inc.</i>		24a. ADDRESS <i>8434 Georgia Ave. Silver Spring, Md.</i>		25a. REC'D BY REGISTRAR <i>Charles Judge</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED NAME (Type or Print)		First	Middle	Last	2a DATE KNOWN OF DEATH				Month	Day	Year	2b HOUR	
Sidney				HERMAN	X				July	15	1968	8:30 PM	
3 SEX	4 RACE	5 DATE OF BIRTH		6 AGE (In years last birthday)	IF UNDER 1 YEAR	YEAR	IF UNDER 24 HRS	2c DATE PRONOUNCED DEAD		Month	Day	Year	2d HOUR
M.	W.	4-20-1923		45 YRS	MONTHS	DAYS	HOURS	MIN	July	15	1968	9:30 PM	
7a BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9 COUNTY OF DEATH							
D.C.		U.S.A.				Montgomery Md							
10 CITY OR TOWN OF DEATH				11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)				12b KIND OF BUSINESS OR INDUSTRY	
Kensington				5315 Flanders Ave.				Dentist				Dentistry	
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE				13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS?		13e STREET AND NUMBER			
Md.				Montgomery		Kensington		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		5315 Flanders Ave			
14 FATHER'S NAME				15 MOTHER'S MAIDEN NAME									
First Middle Last				First Middle Last									
Louis				HERMAN		CELIA							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16b SOCIAL SECURITY NO		17 INFORMANT							
Yes				WWII		BROTHER							
						Dr. Elton Herman 12005 Oldchess Dr. Md.							
18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c))												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY:													
IMMEDIATE CAUSE (a) Coronary insufficiency												1 1/2 yrs.	
DUE TO, OR AS A CONSEQUENCE OF													
Severe coronary arteriosclerosis												years.	
DUE TO, OR AS A CONSEQUENCE OF													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
Myocardial infarction, old with aneurysm, left ventricle													
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY?					
								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				21b TIME OF INJURY Month, Day, Year				21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
				HOUR A.M. P.M. 19									
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
22b. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b DATE SIGNED					
ACTUAL SIGNATURE John H. Ball M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				16 July 68					
EXAMINER'S NAME (Type)				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				ADDRESS (Street, city, town, or county)					
23a BURIAL, CREMATION, REMOVAL (Specify)				23b DATE				23c NAME OF CEMETERY OR CREMATORY				23d LOCATION (City or Town) (County) (State)	
				7/17/68				Old Shalom Cem.				Washington, D.C.	
24. FUNERAL DIRECTOR				ADDRESS				25a REC'D BY REGISTRAR				25b REGISTRAR'S SIGNATURE	
B. Dargatzis & Sons - 3561 14th St NW, WASH. D.C.								JUL 18 1968				Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1, and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED NAME (Type or print) <i>Katherine E Higgins</i>						2a. DATE OF DEATH Month <i>July</i> Day <i>22</i> Year <i>1968</i>			2b. HOUR <i>1:30</i> M		
3. SEX <i>Female</i>		4. RACE <i>W</i>		5. DATE OF BIRTH <i>9/22/21</i>		6. AGE (in years last birthday) <i>46</i> YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <i>Conn</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i> Md.					
10. CITY OR TOWN OF DEATH <i>Bethesda</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Housewife</i>				12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <i>md</i>		13b. COUNTY <i>Mont</i>		13c. CITY OR TOWN <i>Rockville</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>6105 Coonstantine Rd</i>			
14. FATHER'S NAME First Middle Last <i>Glendon A Scoboria</i>				15. MOTHER'S MAIDEN NAME First Middle Last <i>Nan Wilson</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown				16b. SOCIAL SECURITY NO		17. INFORMANT Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Adenocarcinoma ovary with widespread metastasis</i> <i>1830</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION <i>1/20/68</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>CA of ovary</i>				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from <i>1/20</i> , 19 <i>68</i> , to <i>7/22</i> , 19 <i>68</i> , that (I) (we) lost saw the deceased alive on <i>7/22</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Richard C. Myers</i>						DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>7/23/68</i>			
22d. PHYSICIAN'S NAME (Type) <i>Richard C. Myers</i>		22e. ADDRESS <i>8512 Old Georgetown Rd. Bethesda</i>									
23a. BURIAL, CREMATION, REINTERMENT <i>burial</i>		23b. DATE <i>7-23-68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill Crematory</i>		23d. LOCATION (City or Town) (County) (State) <i>Suitland Pr. Geo Md</i>					
24. FUNERAL DIRECTOR Robert A Pumphrey 7557 Wisconsin Ave Bethesda, Md						25a. REC'D BY REGISTRAR DATE <i>JUL 24 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Jones</i>			

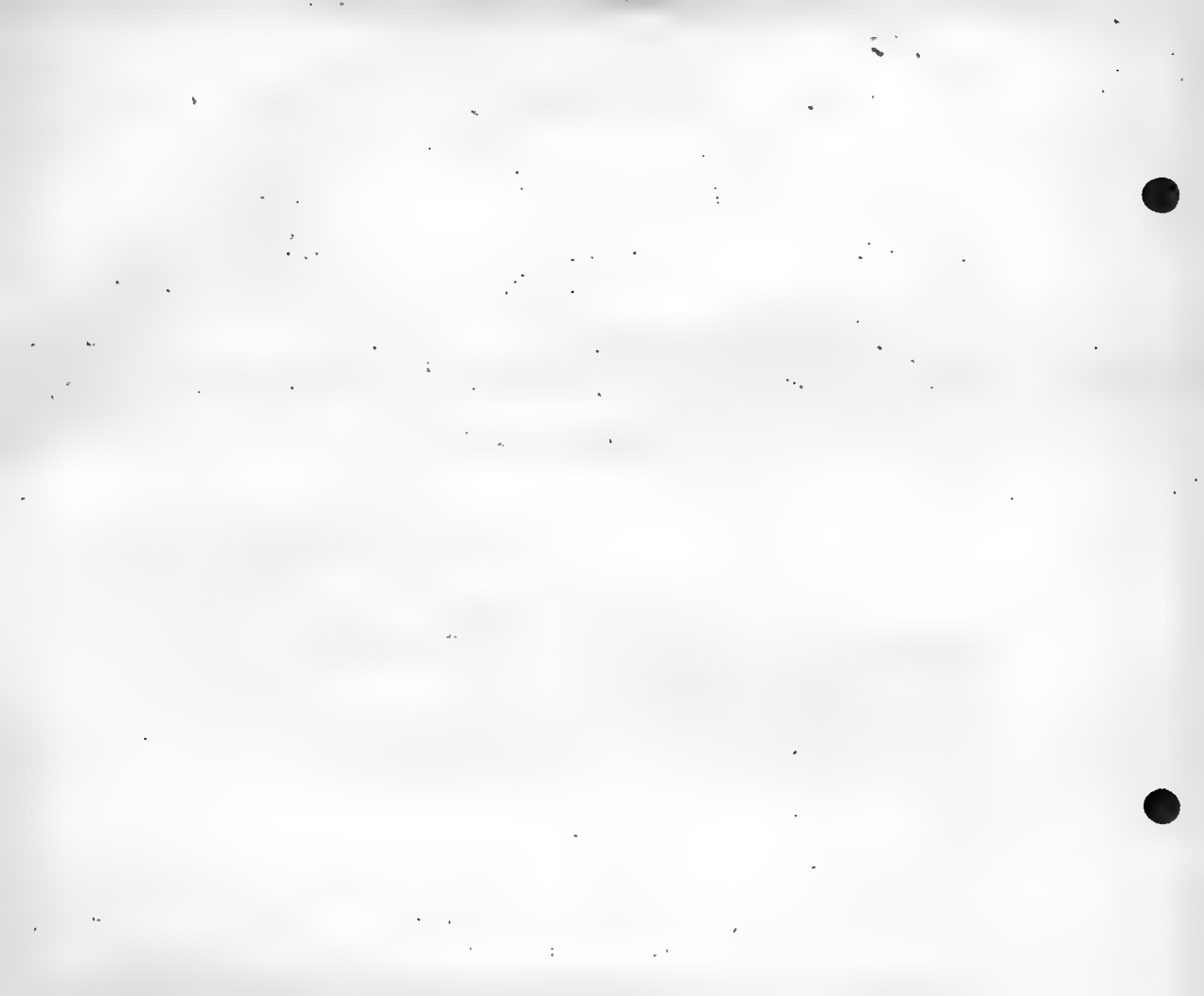


TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (A)
30M REV U6B

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
 CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print)		First <i>Arthur</i>		Middle <i>W</i>		Last <i>Holtzberg</i>		2c DATE OF DEATH		Month <i>July</i>		Day <i>8</i>		Year <i>1968</i>		2b HOUR <i>8:57 AM</i>	
3 SEX <i>male</i>		4 RACE <i>white</i>		5 DATE OF BIRTH <i>April 22-1889</i>		6 AGE (In years last birthday) <i>79</i>		7 UNDER 1 YEAR MONTHS <i>79</i>		DAYS		8 UNDER 24 HRS. HOURS		MIN.			
7a BIRTHPLACE (State or foreign country) <i>Illinois</i>		7b CITIZEN OF WHAT COUNTRY? <i>USA</i>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <i>Montgomery</i>											
10 CITY OR TOWN OF DEATH <i>Bethesda</i>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban</i>		12a USUAL OCCUPATION (Kind of work done during most of working life, even if not red) <i>Editor</i>		12b KIND OF BUSINESS OR INDUSTRY											
13a U.S.A. RESIDENCE (Where deceased admission) STATE <i>DC</i>		13b CITY OR TOWN <i>Washington</i>		13c INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13d STREET AND NUMBER <i>5371 28th St - NW</i>											
14 FATHER'S NAME		First <i>Charles</i>		Middle <i>Victor</i>		Last <i>Holtzberg</i>		15 MOTHER'S MAIDEN NAME		First <i>Hilda</i>		Middle <i>Johnson</i>		Last <i>Johnson</i>			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, <input type="checkbox"/> No, <input checked="" type="checkbox"/> (If yes give year or dates of service) <i>No</i>		16b SOCIAL SECURITY NO. <i>577-48-1552A</i>		17 INFORMANT <i>Mrs Sylvia Holtzberg - above (wife)</i>		Address											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary insufficiency</u> <i>4119</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) _____																APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?									
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR. CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)													
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No				City or Town		County		State					
22a. I certify that (I) (the hospital) attended the deceased from <i>Jan 25</i> , 1964, to <i>July 8</i> , 1968, that (I) (we) last saw the deceased alive on <i>July 8</i> , 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b SIGNATURE <i>Alfred S. Norton M.D.</i>		22c. DEGREE <i>M.D.</i>		22d. ATTENDING PHYS. <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22e. DATE SIGNED <i>7/8/68</i>											
22d. PHYSICIAN'S NAME (Type) <i>Alfred S. Norton</i>		22e. ADDRESS <i>77100 Dwight Drive, Bethesda, Maryland</i>															
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE <i>7-11-1968</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Fort Lincoln Cemetery</i>		23d LOCATION (City or Town) <i>Bladensburg, Prince Georges</i>		(County)		(State)							
24 FUNERAL DIRECTOR <i>Joseph Gayler's Sons, Inc.,</i>		ADDRESS <i>N.W., Wash., D.C., 20016</i>		25a REC'D BY REGISTRAR <i>JUL 11 1968</i>		25b REGISTRAR'S SIGNATURE <i>Charles Judge</i>		Md.									

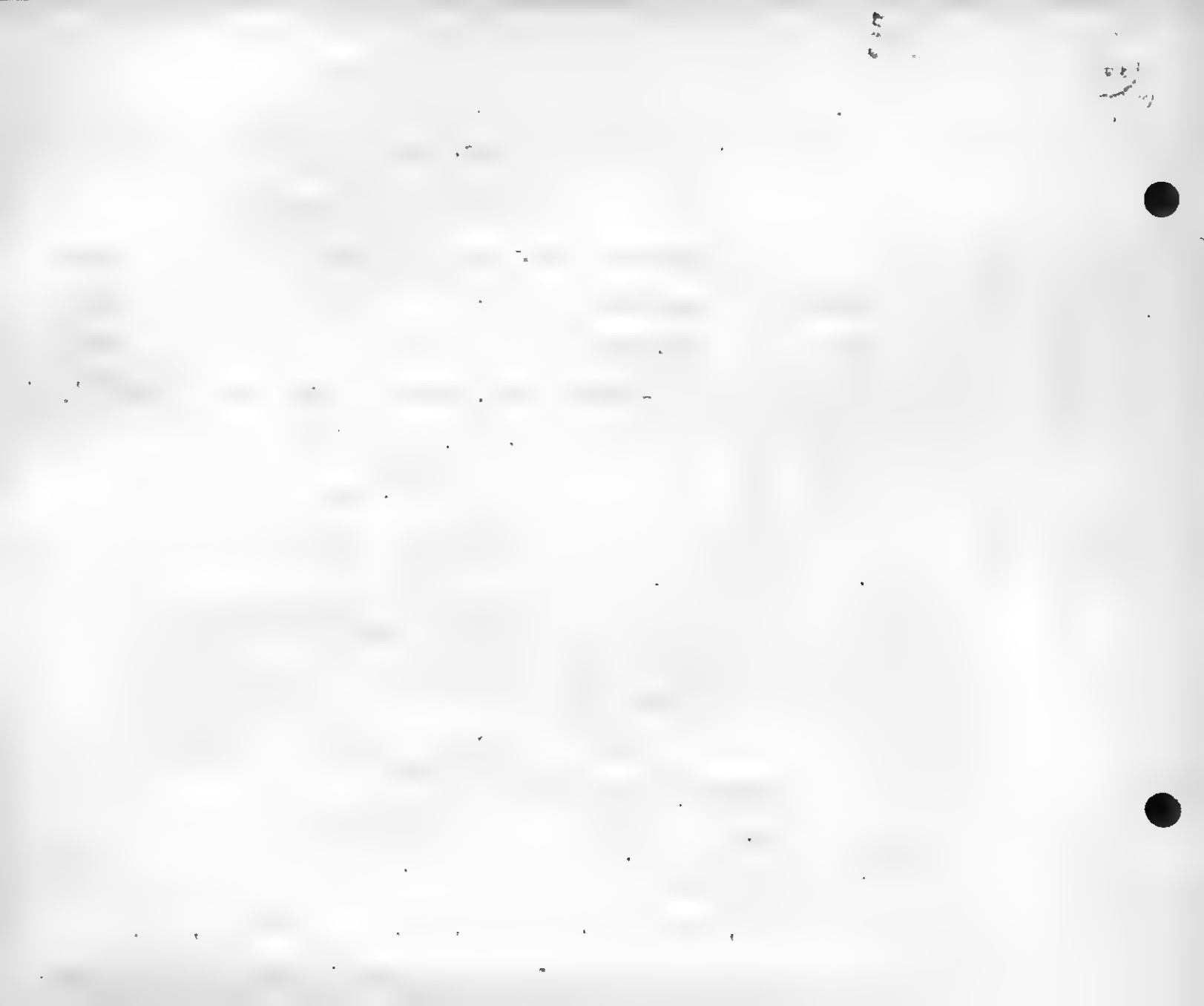


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

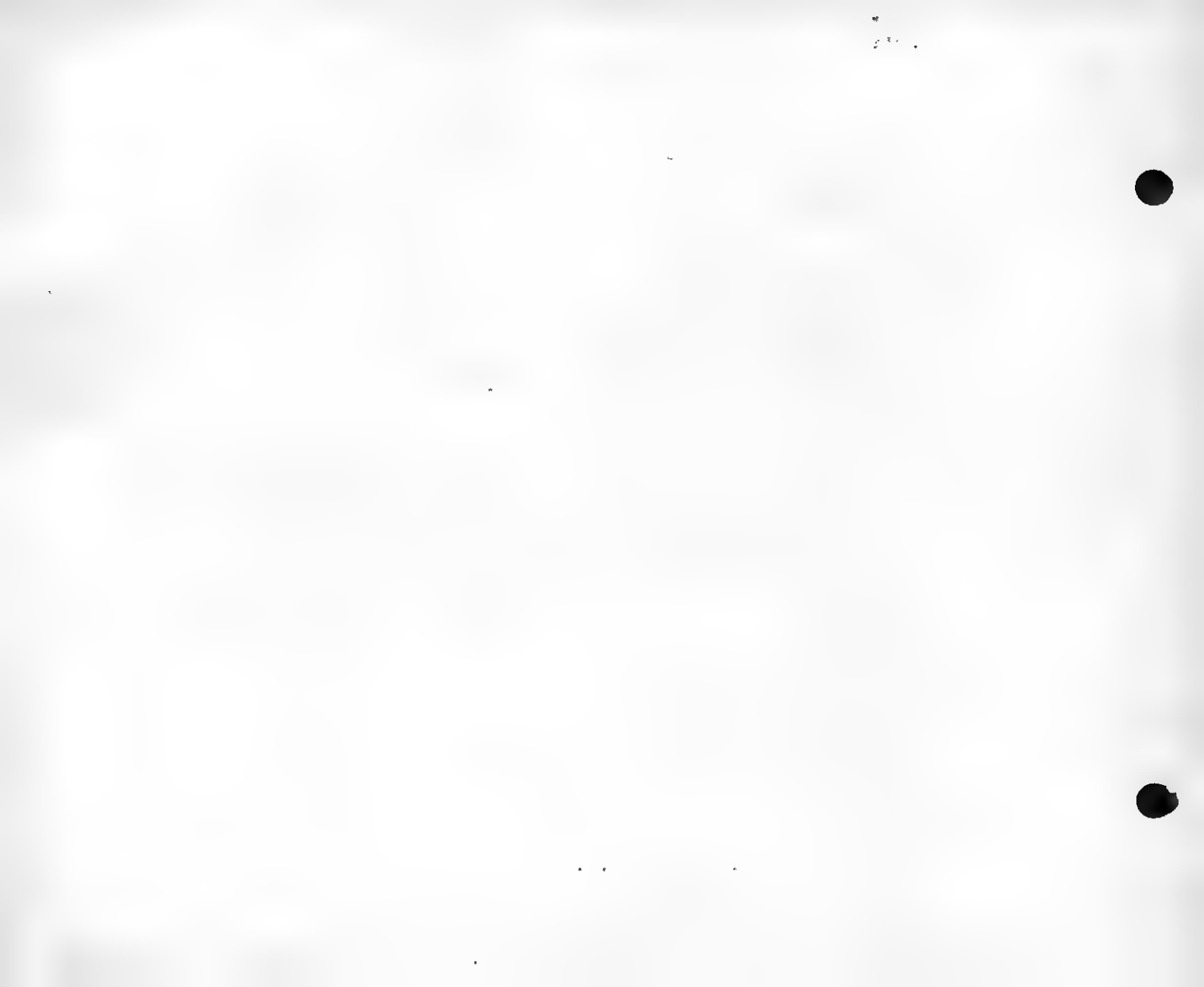
1. DECEASED NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH		2b. HOUR	
Israel				Holtzman	Month 7 Day 14 Year 68		10:32 P. M.	
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. UNDER 1 YEAR	
Male	White		Dec. 30, 1894		73 YRS.		MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		
Russia		USA				Montgomery Md.		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
Wheaton		University Nursing Home		Dentist		Medical		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER
Maryland		Montgomery		SSpring		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1220 East West Hwy.
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME						
First Middle Last		First Middle Last						
Ruben Holtzman		Annie		(unknown)				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO		17. INFORMANT Address				
Yes		WW I		Bethesda, Md.				
		577-54-2195		Mrs. Eleanor Elzufon, 9806 Inglemere Dr.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Multiple cerebral thrombi								1965
4339 DUE TO, OR AS A CONSEQUENCE OF (b) Generalized arteriosclerosis								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
531X Pneumonia								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
		HOUR A.M. Month Day Year P.M. 19						
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State				
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>								
22a. I certify that (I) (this hospital) attended the deceased from July, 1952, to 7/14, 1968, that (I) (we) last saw the deceased alive on 7/13, 1968 and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE		DEGREE		ATTENDING PHYS.		MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED
Herbert W. Schale								7/14/68
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS						
Herbert W. Schale		1800 Eye St N.W. Wash DC						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
Burial		July 16, 1968		Beth Shalom Cong. Cem.		Washington, D.C.		
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Goldberg Funeral Home		4217 9th Street N.W.		DATE JUL 17 1968		J. Charles Judge		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 Item 23b Film 640277-101-88											
1 DECEASED NAME (Type or print) First Middle Last James Edgar HOOKS						2a DATE OF DEATH Month Day Year July 8 1968			2b HOUR 330P M		
3 SEX Male		4 RACE Caucasian		5 DATE OF BIRTH March 4, 1911		6 AGE (In years last birthday) 57 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN	
7a BIRTHPLACE (State or foreign country) North Carolina		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery			Md		
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Naval Hospital		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Navy/Civil Service		12b KIND OF BUSINESS OR INDUSTRY					
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland		13b. COUNTY		13c CITY OR TOWN Odenton		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 542 Prince Charles Ave.			
14 FATHER'S NAME First Middle Last Matthew Hooks				15 MOTHER'S MAIDEN NAME First Middle Last Lucretia Stevens							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16b SOCIAL SECURITY NO (If known, give number or dates of service) WWII		16c SOCIAL SECURITY NO 243 01 7956		17 INFORMANT Mrs. Pauline Hooks		Address Maryland 542 Prince Charles Ave.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary embolization, massive DUE TO, OR AS A CONSEQUENCE OF (b) Squamous cell carcinoma of the lung with cerebral metastases DUE TO, OR AS A CONSEQUENCE OF (c) metastases Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 163X											
19a DATE OF OPERATION		19b. CONDIT.ON FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f LOCATION Street or R.F.D. No		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from May 21 , 19 68 , to July 8 , 19 68 , that (I) (we) last saw the deceased alive on July 8 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death											
22b SIGNATURE Lawrence J. Mervis		22c DATE SIGNED 9 July 1968		22d PHYSICIAN'S NAME (Type) Lawrence J. Mervis, M.D.		22e ADDRESS Naval Hospital, Bethesda, Maryland					
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE July 11, 68		23c NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery		23d LOCATION (City or Town) (County) (State) Baltimore Maryland					
24 FUNERAL DIRECTOR Howard County Harry H. Witzke		25a REC'D BY REG STRAR DATE JUL 10 1968		25b REGISTRAR'S SIGNATURE John Charles Judge							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1768

10230										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										102-11																																							
1 DECEASED-NAME (Type or print)										First James Middle P Last Horne										2a. DATE OF DEATH Month 7/20/68 Day Year										2b. HOUR 6:21 P																													
3 SEX Male										4. RACE White										5 DATE OF BIRTH July 28 -1894										6 AGE (In years last birthday) 73 YRS.										F. UNDER 1 YEAR MONTHS 9 DAYS 22										IF UNDER 24 HRS HOURS MIN.									
7a. BIRTHPLACE (State or foreign country) Jim Thorpe Pa.										7b. CITIZEN OF WHAT COUNTRY? U.S.A.										8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>										9. COUNTY OF DEATH Montgomery Md.																													
10. CITY OR TOWN OF DEATH Rockville										11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give old address) 7404 Bee Bee Drive										12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Pharmacist										12b. KIND OF BUSINESS OR INDUSTRY																													
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.										13b. COUNTY Montgomery										13c. CITY OR TOWN Rockville										13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										13e. STREET AND NUMBER 7404 Bee Bee Dr.																			
14. FATHER'S NAME First Middle Last George B. Horne										15. MOTHER'S MAIDEN NAME First Middle Last Mary D. Bunting																																																	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown Yes										(If yes give war or dates of service) W.W.I.										16b. SOCIAL SECURITY NO. 578-09-1539										17. INFORMANT Address Alex. Douglas B. Horne 413 Prince St. Va.																													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 days.																																																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Generalized arteriosclerosis</u>																																																											
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>										20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																													
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19										21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																																							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) (OFFICE BUILDING, ETC)										21f. LOCATION Street or R.F.D. No City or Town County State																																							
22a. I certify that (I) (this hospital) attended the deceased from <u>1966</u> , 19 <u>66</u> , to <u>7/20/68</u> , 19 <u>68</u> , that (I) (we) lost saw the deceased alive on <u>7/20/68</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																																																											
22b. SIGNATURE <u>Henry C. Serugos</u>										DEGREE M.D.										ATTENDING PHYS. <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>										22c. DATE SIGNED 7/24/68																													
22d. PHYSICIAN'S NAME (Type) <u>Henry C. Serugos M.D.</u>										22e. ADDRESS <u>5413 Cedar Lane Bethesda Md.</u>																																																	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial										23b. DATE 7/25/68										23c. NAME OF CEMETERY OR CREMATORY Parklawn Cem.										23d. LOCATION (City or Town) (County) (State) Rockville Montg. Md.																													
24. FUNERAL DIRECTOR <u>Robert A. Pumpshrey</u>										25a. REC'D BY REG STRAR 7557 Wisc. Ave. Bethesda, Md.										25b. REGISTRAR'S SIGNATURE DATE JUL 29 1968 <u>Charles Judge</u>																																							



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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1 DECEASED NAME (Type or print)			First	Middle	Last	2a DATE OF DEATH			2b HOUR
MINNIE Helen HOUSE						July 24 1968			809 M
3 SEX		4 RACE		5. DATE OF BIRTH		6 AGE (In years lost birthday)		7 IF UNDER 1 YEAR	
FEMALE		WHITE		2/3/1893		75 YRS.		MONTHS DAYS HOURS MIN.	
7a BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Locust Grove, Md.		U. S. A.				MONTGOMERY Md			
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY
BETHESDA			SUBURBAN			Housewife			Own Home
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b COUNTY		13c CITY OR TOWN	13d INSIDE CITY LIMITS?		13e STREET AND NUMBER	
Maryland			Washington		Boonsboro	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First Middle Last
Sampson					Offenberger	Susan			Palmer
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SECURITY NO		17 INFORMANT Address				
No.			214-54-0096		Mrs. Leonard M. Smith, Rfd. 2, Myersville, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) <u>Syptic shock</u>									4 days
DUE TO, OR AS A CONSEQUENCE OF (b) <u>peritonitis</u>									4 days
DUE TO, OR AS A CONSEQUENCE OF (c) <u>raptured sigmoid diverticulum</u>									4 days
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
5721 <u>Toxic myocarditis</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
7/21/68		perforation of sigmoid			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
		HOUR A.M. Month Day Year							
21d INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)			21f LOCATION Street or R.F.D. No. City or Town County State				
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>									
22a I certify that (I) (this hospital) attended the deceased from <u>7/19</u> , 19 <u>68</u> , to <u>7/24</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>7/24</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death.									
22b SIGNATURE <u>Arthur W. Gray, MD</u>					22c. DATE SIGNED <u>7/25/68</u>				
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS				
					8218 Wisconsin Ave.				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		7-29-68		Boonsboro Cemetery		Boonsboro, Wash. Co., Md.			
24 FUNERAL DIRECTOR ADDRESS					25a REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
John H. Bast, Jr. 112 N. Main St. Boonsboro, Md					JUL 30 1968		<u>Charles Judge</u>		



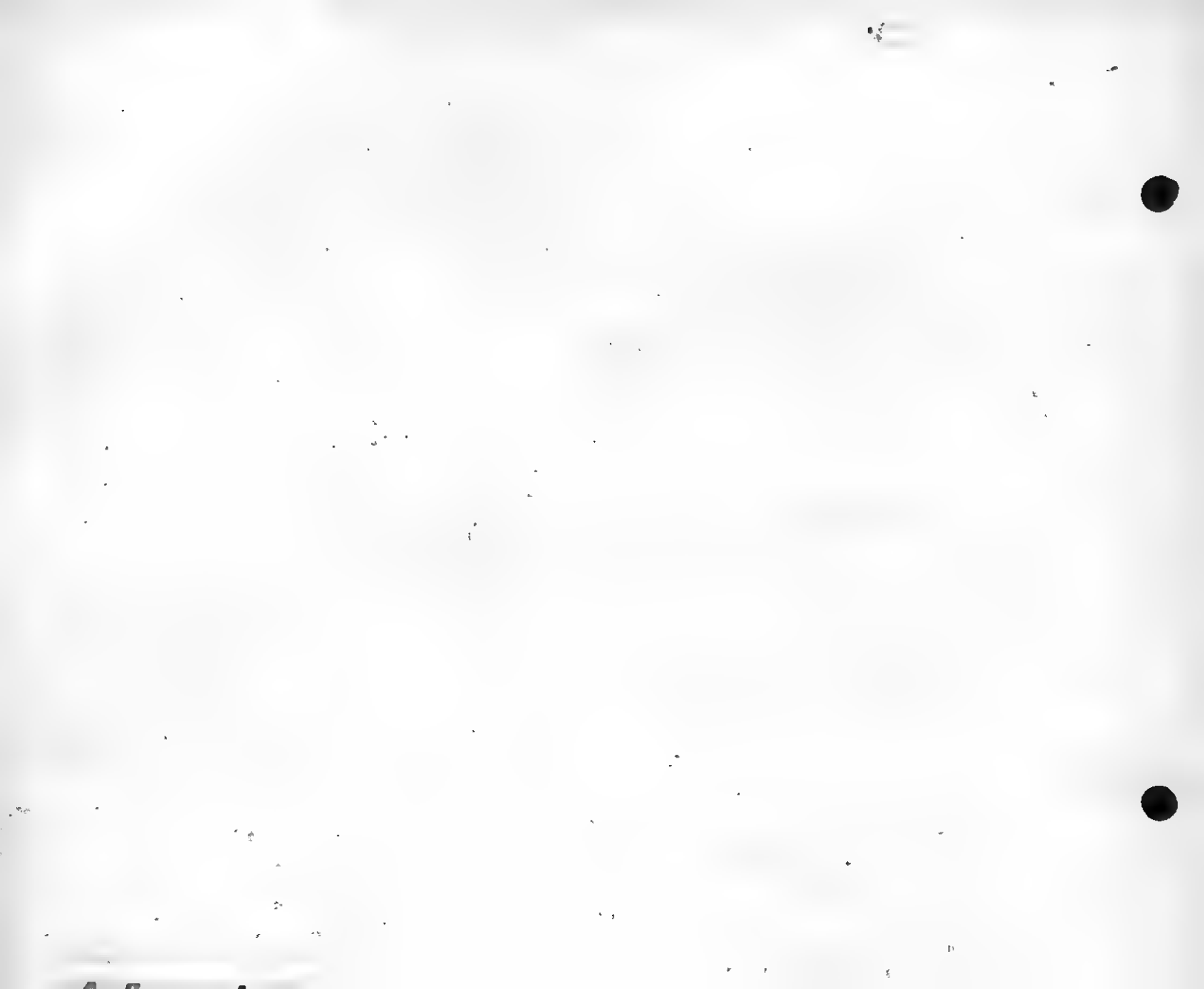
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) <i>Sarah Dean Huff</i>			2a. DATE OF DEATH Month <i>July</i> Day <i>27</i> Year <i>1968</i> 9 ⁴⁵ P M		
3 SEX <i>Female</i>	4. RACE <i>White</i>	5. DATE OF BIRTH <i>July 31 1908</i> 59 YRS.		6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS HOURS M N
7a. BIRTHPLACE (State or foreign country) <i>Maryland</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U. S.</i>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <i>Montgomery</i> Md		
10. CITY OR TOWN OF DEATH <i>Bethesda</i>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Maple Ave</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md</i>	13b. COUNTY <i>Mont</i>	13c. CITY OR TOWN <i>Bethesda</i>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <i>Maple Ave 4529</i>	
14. FATHER'S NAME First <i>J.</i> Middle <i>W.</i> Last <i>Dean</i>	15. MOTHER'S MAIDEN NAME First <i>Edith</i> Middle <i>A.</i> Last <i>Collins</i>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <i>No</i>	16b. SOCIAL SECURITY NO. <i>Unknown</i>	17. INFORMANT <i>Alvethorne 1st Cousin</i>		Address <i>4859 Old Dominion Rd. Arlington</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>cardio-respiratory failure</i> 7309 DUE TO, OR AS A CONSEQUENCE OF (b) <i>diabetes; increasing heart disease</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>last</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH. <i>4 hrs</i> <i>15 yrs.</i>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>carbone R+ thigh.</i>					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State		
22a. I certify that (I) (this hospital) attended the deceased from <i>Sept 1953</i> , to <i>27 July 1968</i> , that (I) (we) last saw the deceased alive on <i>27 July 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>John M. Wyman</i>		DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED <i>7/28/68</i>		
22d. PHYSICIAN'S NAME (Type) <i>John M. Wyman</i>		22e. ADDRESS <i>7801 NORFOLK Bethesda, Md.</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE <i>7-30-68</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Mt. Zion Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Bethesda, Maryland</i>	
24. FUNERAL DIRECTOR <i>ROBERT A. PUMPHREY, Bethesda, Maryland</i>		25a. REC'D BY REGISTRAR <i>UL 31 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. (Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

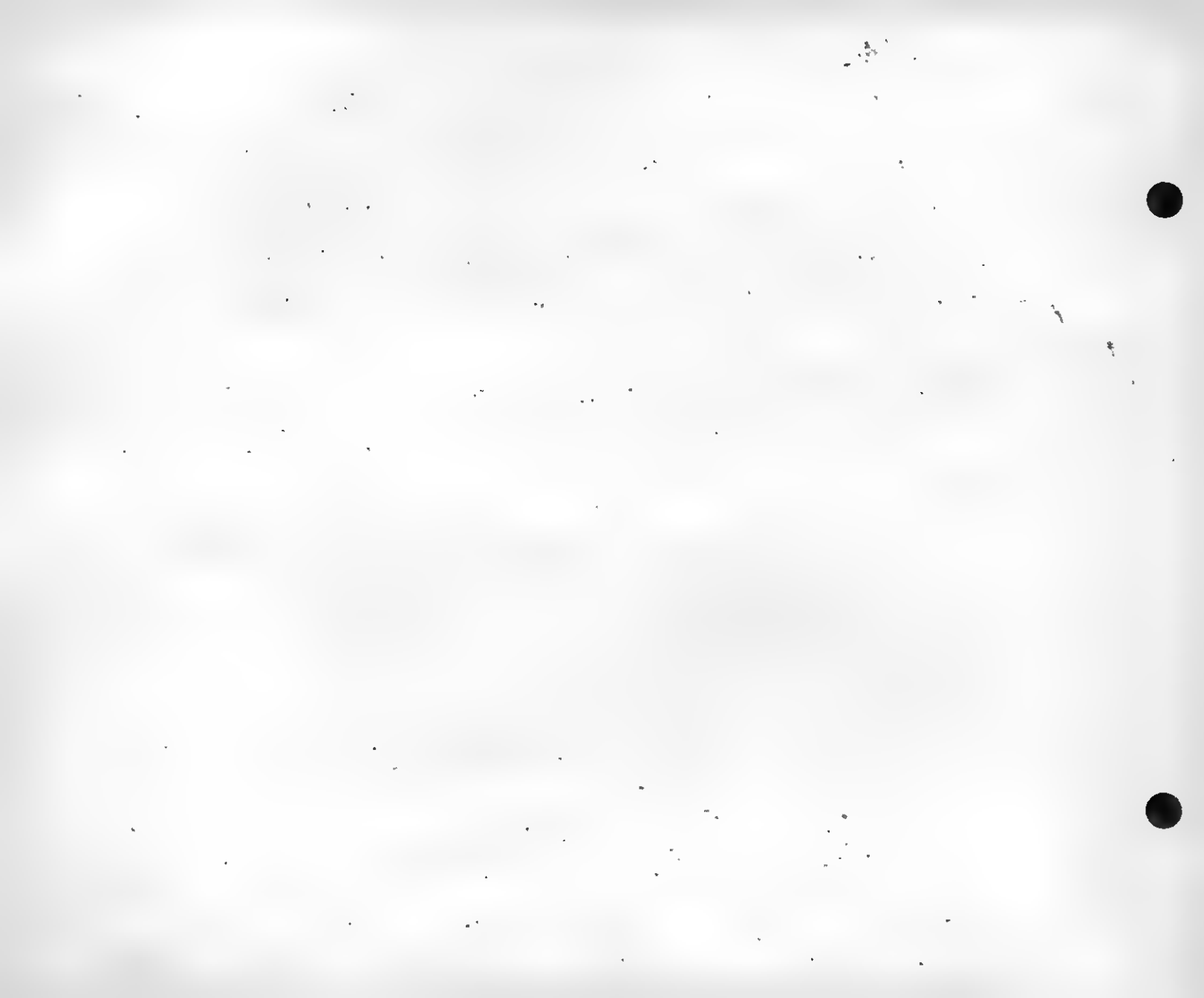




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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1 DECEASED NAME (Type or print) First Middle Last Robert Luther Hurley						2a DATE OF DEATH Month Day Year July 1 1968			2b HOUR 4:10 P.M.		
3 SEX male		4 RACE white		5 DATE OF BIRTH 4-23-10		6 AGE (In years last birthday) 58 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a BIRTHPLACE (State or foreign country) Del.		7b CIT. ZEN OF WHAT COUNTRY? Amer		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.					
10 CITY OR TOWN OF DEATH Takoma Park			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington Sanatorium & Hosp			12a. USUAL OCCUPATION (Kind of work done during most of working life, even retired) Telephone Co.			12b. KIND OF BUSINESS OR INDUSTRY		
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland			13b. COUNTY Montgomery			13c CITY OR TOWN Takoma Park		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 8608 Barron St.	
14 FATHER'S NAME First Middle Last Leon S. Hurley				15. MOTHER'S MAIDEN NAME First Middle Last Addie Sirman							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) No				16b SOCIAL SECURITY NO 571-01-273		17 INFORMANT Address Med. Records - W. S. H.					
18. CAUSE OF DEATH (Enter only one cause per line of (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Generalized Carcinomatosis DUE TO, OR AS A CONSEQUENCE OF (b) Squamous cell Ca of Hypopharynx Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 mos. 10 mos	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) None											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from 7/1/68 , 19 68 , to 7/1 , 19 68 , that (I) (we) last saw the deceased alive on 7/1 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b SIGNATURE HARRY N. CARLTON				22c. PHYSICIAN'S NAME (Type) HARRY N. CARLTON MD				22d ADDRESS 8801 Colsonville Rd, Elmer, Md		22e. DATE SIGNED 7/1/68	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE July 5, 1968		23c NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery				23d LOCATION (City or Town) (County) (State) Landover Md.			
24. FUNERAL DIRECTOR William Walker				ADDRESS 252 Carroll St NW				25a REC'D BY REGISTRAR JUL - 5 1968		25b REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year		2b. HOUR	
Rudolph Ernest JACKLE						July 11 68		510P M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years lost birthday)		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS M.M.	
Male		Caucasian		9 Oct. 1936		31 YRS			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH			
New York		USA				Montgomery		Md	
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
Bethesda			Naval Hospital			U. S. Navy			
13a. USUAL RESIDENCE (Where deceased lived, or institution or residence before admission) STATE			13b. CITY OR TOWN			13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland			St. Marys			Lexington /		260 King Drive	
14 FATHER'S NAME First Middle Last			15 MOTHER'S MAIDEN NAME First Middle Last						
Hugo Jackle			Johanna K. Schriener						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) Yes, No, or unknown			16b. SOCIAL SECURITY NO		17. INFORMANT Address				
Yes 1955-1968			003 24 80		Mrs. Doris M. Jackle, 260 King Dr. Lexington				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH CAUSED BY: IMMEDIATE CAUSE (a) Amyloidosis with consumptive coagulopathy									
216X DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
(b) DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC		21f. LOCATION Street or R.F.D. No		City or Town		County State	
22a. I certify that (X) (this hospital attended the deceased from Dec. 14, 1968, to July 11, 1968, that (X) (we) last saw the deceased alive on July 11, 1968, and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (do not) view the body after death.									
22b. SIGNATURE					ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED		
Name (MacMahon)					DEGREE		July 12, 1968		
22d. PHYSICIAN'S NAME (Type) Frank BLACKBURN, M.D.					22e. ADDRESS Naval Hospital, Bethesda, Maryland				
23a. BURIAL, CREMATION, REMOVAL, OR OTHER		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		7/16/68		Arlington National Cemetery, Arlington, Virginia					
24. FUNERAL DIRECTOR W. W. CHAMBERS CO. ADDRESS					25a. RECORD REQUESTED JUL 17 1968		25b. RECORD REQUESTER'S SIGNATURE		
1400 Chapin Street, N.W., Washington, D.C.					DATE		J. Charles Judge		



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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
10236									
CERTIFICATE OF DEATH									
1 DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year			2b. HOUR
Jennie			M. Jackson			July 24 1968			3:10A M
3 SEX		4. RACE		5. DATE OF BIRTH			6 AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS
Female		White		May 22, 1882			86 YRS.		IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH
Tataganogahne Nova Scotia, Canada			U. S. A.			Montgomery			Md
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY
Wheaton			4209 Inlure Drive			Governess			Private Home
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
Md.			Montgomery			Wheaton			4209 Inlure Drive
14 FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
Nathaniel Forbes			Olive Thompson						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO			17 INFORMANT			4209 Inlure Drive
No			yes 023-22-0759			Jeanette Dinwoodie			Wheaton, Md.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Uremia</u> <u>185X</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Common of bladder</u> DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>2 mo</u>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <u>June</u> , 19 <u>68</u> , to <u>July 24</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>9/25</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>John S. Sora</u>					DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>24 July 68</u>		
22d. PHYSICIAN'S NAME (Type) <u>Dr. John Sora</u>					22e. ADDRESS <u>809 Vreiss Mill Rd</u>				
23a. BURIAL, CREMATION REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
Burial		July 26, 1968		Brookdale Cemetery			Dedham, Massachusetts		
24. FUNERAL DIRECTOR <u>Warner E. Humphrey, Inc.</u>					25. REC'D BY REGISTRAR <u>JUL 26 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

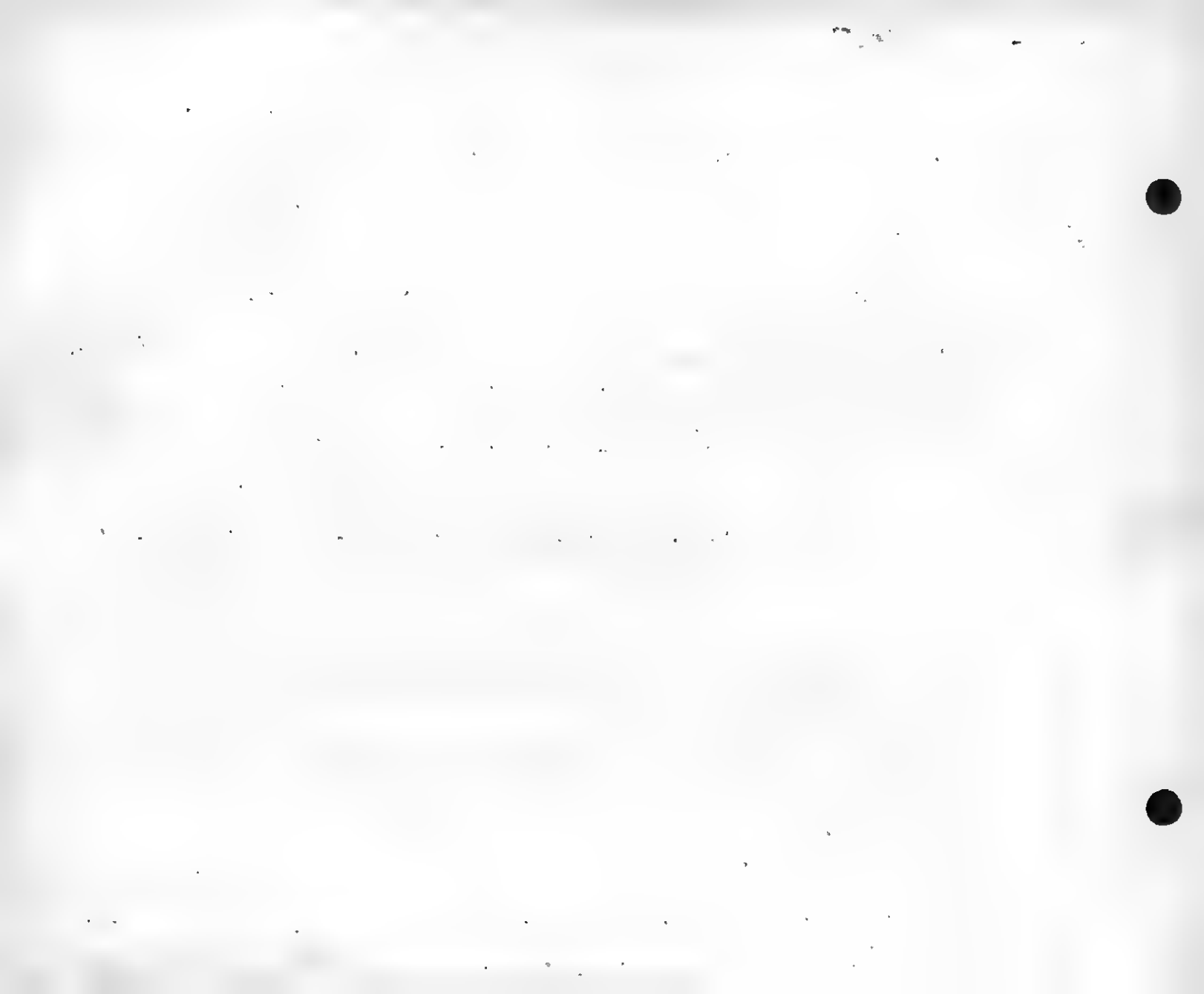


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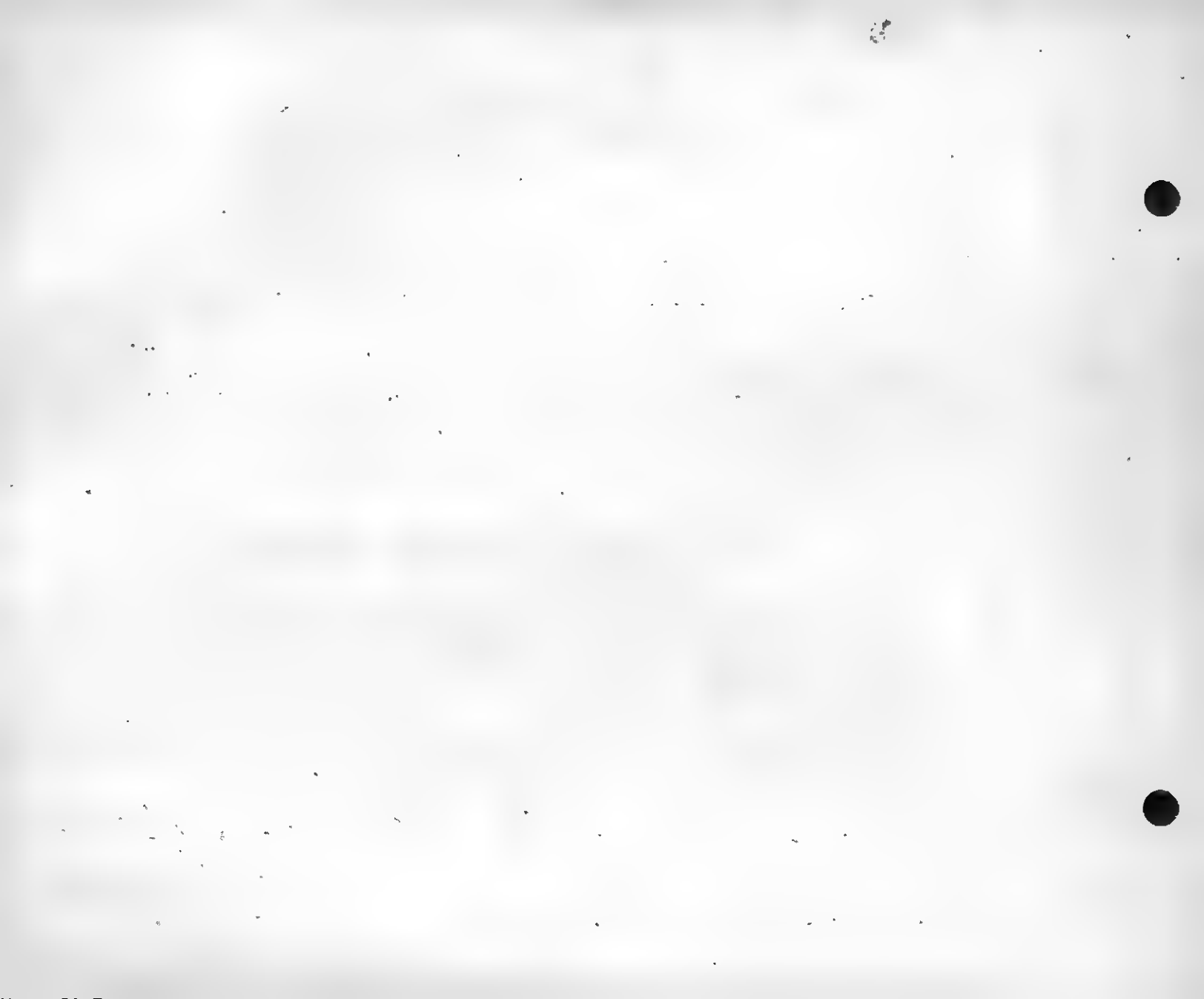
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201															
CERTIFICATE OF DEATH															
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH		2b. HOUR							
Gordon			E.		Jacobs	July 5 1968		2:45 A M							
3 SEX		4. RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		7 LINDER 1 YEAR							
MALE		White		February 13, 1958		10		MONTHS DAYS HOURS MIN							
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH									
Ohio		United States				MONTGOMERY Md.									
10. CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY							
Silver Spring			Holy Cross												
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER						
Md.			MONT.		ROCKVILLE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		4100 ELIZABETH ST.						
14. FATHER'S NAME			First	Middle	Last	15 MOTHER'S MAIDEN NAME			First	Middle	Last				
WARREN			L.		JACOBS	AUBRIANNE					HADDAD				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT									
NO			NONE			WARREN L JACOBS SAME AS #13E									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Bronchopneumonia bilateral</u>										Less than 24 hrs					
DUE TO, OR AS A CONSEQUENCE OF (b) <u>3° Burns 45% body surface</u>															
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Patent ductus + ventricular septal defect</u>															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)															
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
None												YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		Yes	
21a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18.)			
										HOUR A.M. Month Day Year		Flame burn			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work										21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)		21f. LOCATION Street or RFD No City or Town County State			
										Home		Silver Spring Montg Md			
22a. I certify that (I) (this hospital) attended the deceased from <u>6-1-1968</u> to <u>7-5-1968</u> , that (I) (we) lost saw the deceased alive on <u>7-4-1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												Accident			
22b. SIGNATURE <u>Thomas L. Kury, MD</u>										22c. DATE SIGNED		7-5-68			
22d. PHYSICIAN'S NAME (Type) <u>THOMAS L KURY</u>										22e. ADDRESS		ROCKVILLE MD			
23a. BURIAL CREMATION, REMOVAL (Specify)										23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)	
BURIAL										7-8-68		GATE OF HEAVEN		WHEATON MD	
24 FUNERAL DIRECTOR <u>W.W. Chambers Co Silver Spring Md</u>										25a. REC'D BY REGISTRAR <u>JUL - 9 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED NAME (Type or print)			First		Middle		Last		2a. DATE OF DEATH Month Day Year		
RUSSEL			JON		JANSEN				July 23 1968		
3 SEX		4 RACE		5 DATE OF BIRTH			6 AGE (In years lost birthday)		7b. IF UNDER 1 YEAR MONTHS DAYS		
MALE		CAUCASIAN		10/28/1899			68 YRS				
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Minnesota			U.S.A.					MONTGOMERY Md			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
BETHESDA			SUBURBAN HOSPITAL			Physician			SELF		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
DC						WASHINGTON		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		7066 WYNDALE ST., N.W.	
14. FATHER'S NAME			15. MOTHER'S M.A.DEN NAME								
First Middle Last			First Middle Last								
JOHN JANSEN			LAVINIA HENNING								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or Unknown			16b. SOCIAL SECURITY NO.			17. INFORMANT			Address		
YES			1ST W.W.			CAROL MONCHICK - 2801 GREENVALE ST.			GREEN CHASE, MD		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial Infarction											
4109 DUE TO, OR AS A CONSEQUENCE OF (b) Coronary Arteriosclerosis Heart Disease										2 years	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
4201											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (the hospital) attended the deceased from 1955, to July 23, 1968, that (I) (we) last saw the deceased alive on 7/22/1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (and) (did not) view the body after death.											
22b. SIGNATURE			22c. DATE SIGNED								
J. LAWN THOMPSON, M.D.			7/23/68								
22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS								
J. LAWN THOMPSON, M.D.			1714 N. ST., N.W., WASHINGTON, D.C.								
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
Burial			7-26-1968			Rock Creek Cemetery			Washington, D.C.		
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
JOS. GAWLER'S SONS, 5130 Wis. Ave, NW, Wash, DC						JUL 26 1968			Charles Judge		



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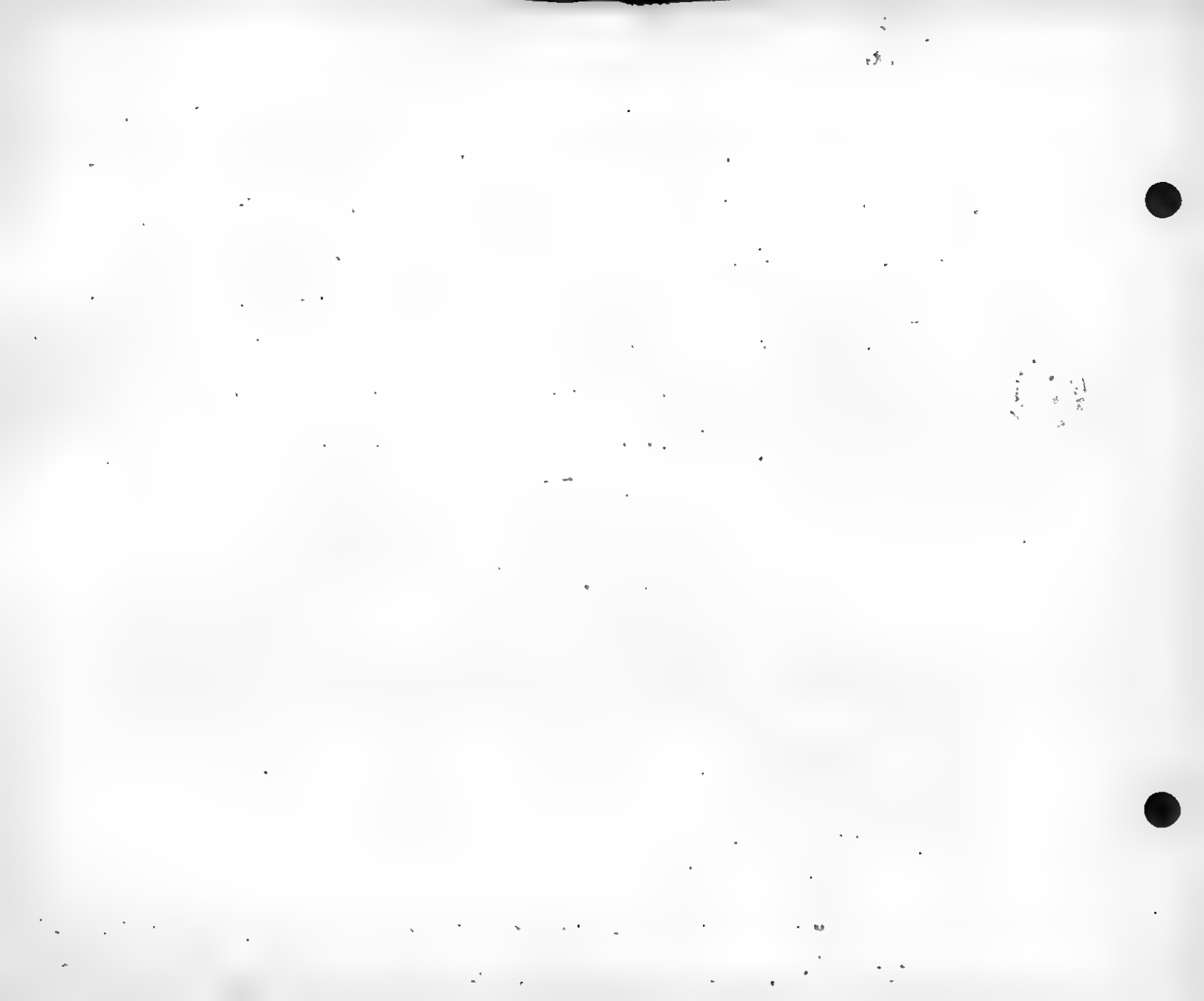
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10039

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

10040

1. DECEASED NAME (Type or print) HARRY RUSSELL JENKINS, SR.			2a. DATE OF DEATH Month 7 Day 28 Year 1968			2b. HOUR 10:08 AM	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH 5-28-1894		6. AGE (in years last birthday) 74 YRS	
7a. BIRTHPLACE (State or foreign country) WASHINGTON DC		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH MONTGOMERY Md.	
10. CITY OR TOWN OF DEATH SILVER SPRING		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 10202 PROCTOR STREET		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) PLUMBER		12b. KIND OF BUSINESS OR INDUSTRY THUMBING	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland		13b. COUNTY Montg		13c. CITY OR TOWN SILVER SPRING		13d. RESIDE CITY LIM. 157 YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 10202 PROCTOR ST		14. FATHER'S NAME First DAVID Middle E Last JENKINS		15. MOTHER'S MAIDEN NAME First MARION Middle E Last MAY			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes (no, or unknown) NO (If yes give war or dates of service) -		16b. SOCIAL SECURITY NO. 577-10-7237		17. INFORMANT Address LOUISE GLEASON 4012 ADAMS, Wheaton Md			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 4000 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) Arteriosclerosis slowing the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerosis (c) Arteriosclerosis							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Arteriosclerosis							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 1956 to 28 July 1968 , that (I) (we) lost saw the deceased alive on 28 July 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE William D. Auld M.D. DEGREE				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 7/28/68	
22d. PHYSICIAN'S NAME (Type) WILLIAM D. AULD				22e. ADDRESS 9006 COLESVILLE RD. S.S. MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE August 1, 1968		23c. NAME OF CEMETERY OR CREMATORY St. Lincoln Cemetery		23d. LOCATION (City or Town) (County) (State) Prince George's County, Md.	
24. FUNERAL DIRECTOR Warner E. Humphrey, Inc., Silver Spring, Md.				25a. REC'D BY REG. STRAR DATE AUG 2 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-1. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 18-22a film 402 MARYLAND STATE DEPARTMENT OF HEALTH
7-29-68 mt DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10040

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH			Month Day Year			2b. HOUR	
Walter			R. Jones			X			July 14, 1968			3 PM	
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (in years last birthday)	IF UNDER 1 YEAR		F UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD			2d. HOUR		
Mald	Cau	2/22/25	43 YRS	MONTHS	DAYS	HOURS	MIN.	7-14			3 PM		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH							
Idaho		U.S.				Montgomery							
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY				
Silver Spring			Holy Cross			Retired - Air Force			Cock Business				
13a. U.S.A. RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		3d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER				
Maryland			Montgomery		Silver Spring		X NO <input type="checkbox"/>		1804 Eldon La.,				
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME										
Jean Jones Paul Jones			Hazel B. E. Smalley										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO		17. INFORMANT			ADDRESS					
yes			20 years		519-16-5493			Christine Jones, daughter, same address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY:													
IMMEDIATE CAUSE (a) Acute Coronary Insufficiency													
DUE TO, OR AS A CONSEQUENCE OF													
(b) Coronary Artery Heart Disease													
DUE TO, OR AS A CONSEQUENCE OF													
(c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
MEDICAL CERTIFICATION													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?					
								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
				19 P.M.									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED					
EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				July 14, 1968					
Belden R. P. Lee				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>									
				DDRESS (Street, City, Town, or County)									
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
Burial				July 18, 1968		Arlington National Cem.		Arlington, Virginia					
24. FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR				25b. REGISTRAR'S SIGNATURE					
Warner E. Pumphrey, Inc.				JUL 19 1968				J. Charles Jones					



MARYLAND STATE DEPARTMENT OF HEALTH

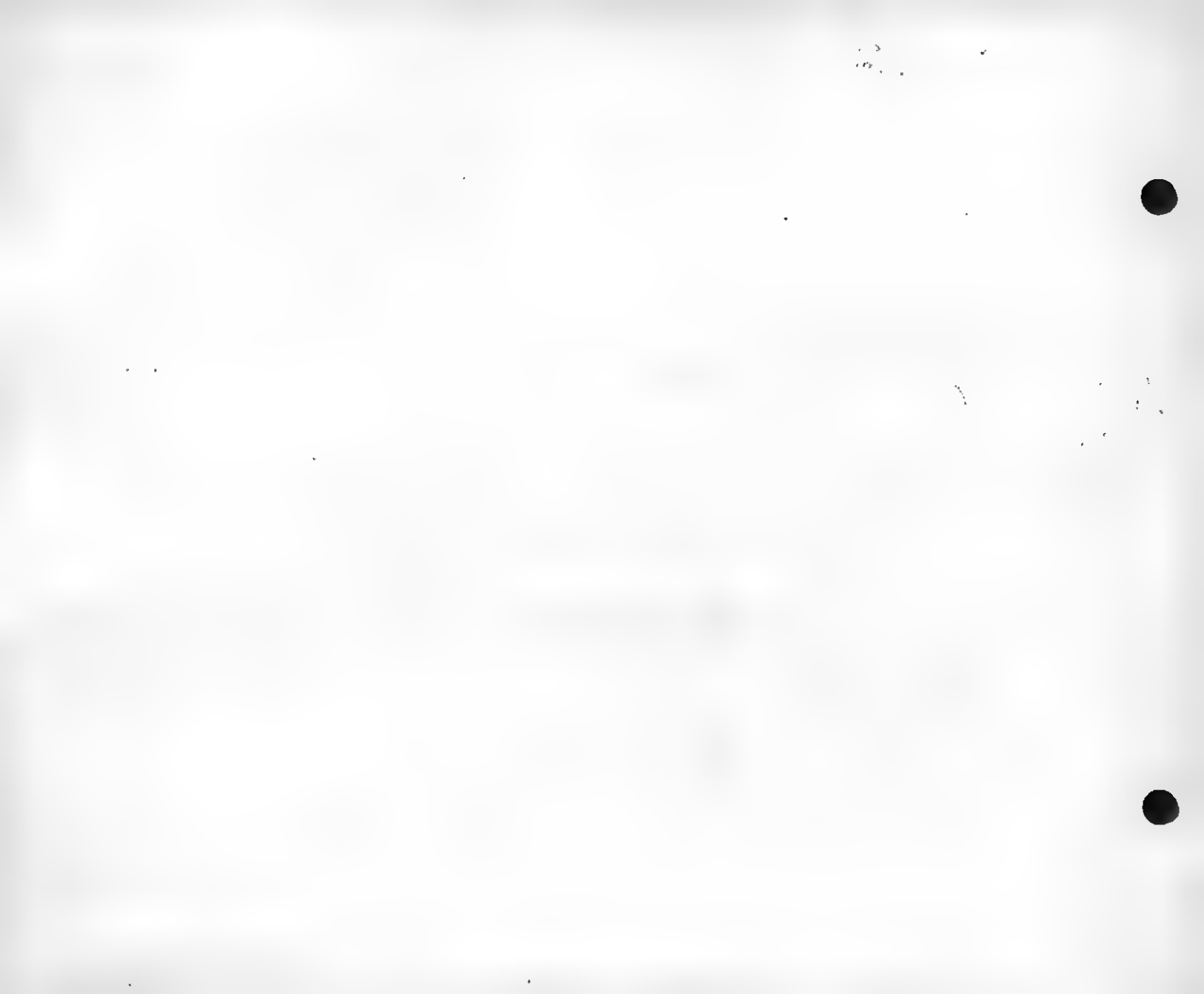
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>3601 Chesterbrook Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>CATHERINE C. KENNY</u>		4 DATE OF DEATH Month <u>July</u> Day <u>13</u> Year <u>1968</u>	
5 SEX <u>Female</u>	6 COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>Jan. 27, 1881</u>
9 AGE (In years last birthday) <u>87</u> yrs		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>--</u>		11 BIRTHPLACE (County & State, or foreign country) <u>Penna.</u>	
12 CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>Henry Kenny</u>	
14. MOTHER'S MAIDEN NAME <u>Catherine L</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>	
16 SOCIAL SECURITY NO. <u>193 38 3394</u>		17 INFORMANT <u>Joseph P. Meinzer, same as 1 & 2.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CEREBRO-VASCULAR ACCIDENT</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) <u>ATHEROSCLEROSIS</u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 DAYS</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>531X</u>		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (U) (this hospital) attended the deceased from <u>10 July</u> , 19 <u>68</u> , to <u>13 July</u> , 19 <u>68</u> , that (U) (we) last saw the deceased alive on <u>12 July</u> , 19 <u>68</u> , and that death occurred at <u>5:20 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Eugene J. Chap</u>		22b. DATE SIGNED <u>July 13, 1968</u>	
22c. PHYSICIAN'S NAME (Type) <u>Eugene J. Chap</u>		22d. ADDRESS <u>1302 18th Street, N.W. Wash. D.C.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>11/17/68</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Cathedral Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Scranton, Penna.</u>
24. FUNERAL DIRECTOR <u>H. Don DeVol</u>		25a. REC'D BY REGISTRAR <u>JUL 19 1968</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		25c. ADDRESS <u>2222 W. Ave. N.W. Washington, D.C.</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year		2b. HOUR		
Priscilla (NMN) Kern						July 17 1968		12:01		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. IF UNDER 1 YEAR MONTHS DAYS		
Female		White		May 28, 1888		80 YRS.				
7a. BIRTH-PLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
New York		America				Montgomery Md.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
Takoma Park			Washington Sanitarium			Housewife		OWN Home		
13a. USUAL RESIDENCE (Where deceased lived if institution Res. dence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland			Montgomery		Rockville		YES		717 Maples Avenue	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last							
? Dexter			Maude A. DEXTON							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT					
no			152-09-0220-8		8. Driver, Kern 717 Maples Avenue, Md. Patient's Chart Rockville, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>negative failure due to ASHD, LBBB</u> 419 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>heart failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>and acute myocardial</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1-2 yrs 20 yrs 9-12 mos										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 4200										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from 7/17/68, to 7/17/68, that (I) (we) last saw the deceased alive on 7/17/68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. <u>Seen about 12 minutes before death</u>										
22b. SIGNATURE <u>Charles H. Volokhov</u>					DEGREE - ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (Type) <u>Charles H. Volokhov</u>					22e. ADDRESS <u>831 Union Blvd E. Silver Spring, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Burial		July 20, 1968		Rock Creek Cemetery		Washington, D. C.				
24. FUNERAL DIRECTOR, LEE <u>Warner E. Pumphrey, Inc.</u>					25a. REC'D BY REGISTRAR <u>8430 Georgia Avenue Silver Spring, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles J. J...</u>			
VR A15 (4) 30M REV. 1/68					DATE <u>JUL 24 1968</u>					



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. DECEASED NAME (Type or Print)			First <i>TIMOTHY</i>			Middle <i>KERWIN</i>			Last		
3. SEX <i>Male</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>7/20/28</i>		6. AGE (in years last birthday) <i>40</i> YRS		IF UNDER 1 YEAR MONTHS <i>0</i> DAYS <i>9</i>		IF UNDER 24 HRS HOURS <i></i> MIN <i></i>	
7a. BIRTHPLACE (State or foreign country) <i>Washington DC</i>			7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <i>Montgomery</i>		
10. CITY OR TOWN OF DEATH <i>Bethesda</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired) <i>Fat Examiner</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>U.S. Gov.</i>		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <i>Md</i>			13b. COUNTY <i>Mont</i>			13c. CITY OR TOWN <i>Bethesda</i>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
13e. STREET AND NUMBER <i>5612 Roswell St.</i>			14. FATHER'S NAME First <i>Charles Henry</i> Middle <i>Kerwin</i> Last <i></i>			15. MOTHER'S MAIDEN NAME First <i>Blanche Marie</i> Middle <i>Lidke</i> Last <i></i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>			16b. SOCIAL SECURITY NO <i>227-30-9077</i>			17. INFORMANT <i>Louise Kerwin</i>			ADDRESS <i></i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pulmonary fat embolism, marked</u>										hours	
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Fractured right femur</u>										2 days	
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Trauma from automobile accident</u>										2 days	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>823 +</i>											
19a. DATE OF OPERATION <i>8/1/68</i>				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i></i>				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				21b. TIME OF INJURY Month, Day, Year <i>11:20 PM July 27 1968</i>				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) <i>Lost control of car, ran into tree -</i>			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory office building, etc) <i>Highway</i>				21f. LOCATION Street or R.F.D. No City or Town County State <i>8000 Black Bush Blvd Bethesda Montgomery Md</i>			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <i>John G. Ball</i>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED <i>July 30, 1968</i>			
EXAMINER'S NAME (Type) <i>John G. Ball M.D.</i>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
ADDRESS (Street, city, town, or county) <i></i>				ADDRESS (Street, city, town, or county) <i></i>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>			23b. DATE <i>8/1/68</i>			23c. NAME OF CEMETERY OR CREMATORY <i>Mt. Zion Cem.</i>			23d. LOCATION (City or Town) (County) (State) <i>Bethesda Montgomery Md.</i>		
24. FUNERAL DIRECTOR <i>Robert A. Pumphrey 7557 Wisconsin Ave. Bethesda, Md.</i>						25a. REC'D BY REGISTRAR DATE <i>AUG 5 1968</i>			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		



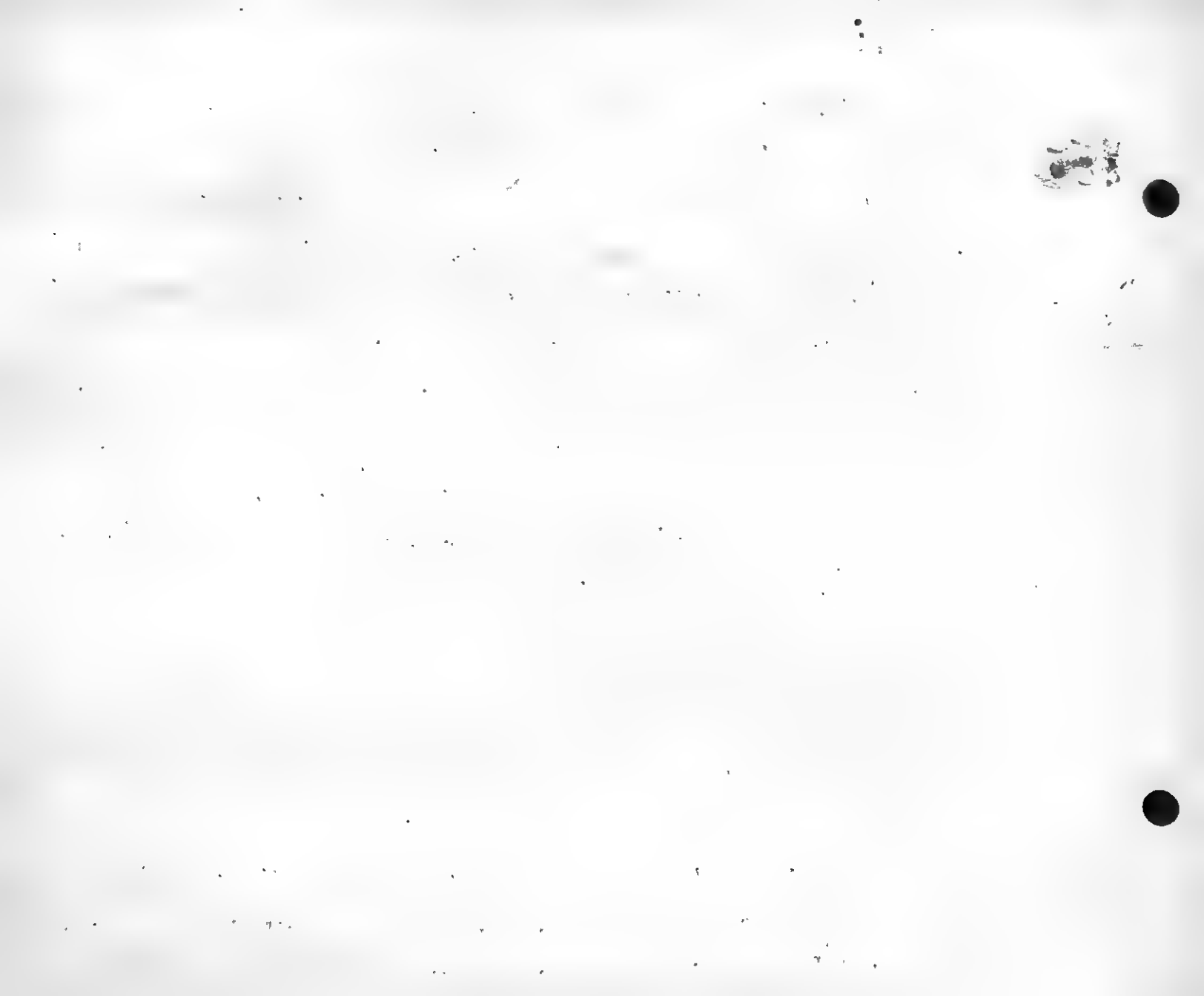
CERTIFICATE OF DEATH

54

1 DECEASED NAME (Type or print)			First <i>Albion</i>	Middle <i>D.</i>	Last <i>Kilbreth</i>	2a. DATE OF DEATH 7 Month 16 Day 68 Year			2b. HOUR 10 ²⁰ AM		
3 SEX <i>Male</i>		4. RACE <i>White</i>		5 DATE OF BIRTH <i>2-16-88</i>		6 AGE (in years last birthday) <i>80</i> YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <i>Maine</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <i>Montgomery County Md.</i>					
10 CITY OR TOWN OF DEATH <i>Silver Spring</i>			11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <i>Holy Cross Hosp.</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Retired Plumber</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>Plumbing</i>		
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE <i>Md.</i>			13b. COUNTY <i>Montgomery Silver Spring</i>			13c. INSUR CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER <i>9710 New Hampshire Ave.</i>			
14. FATHER'S NAME First Middle Last <i>Alfred Leslie Kilbreth</i>			15. MOTHER'S MAIDEN NAME First Middle Last <i>Nettie Dudley</i>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (if yes give war or dates of service)			16b. SOCIAL SECURITY NO. <i>579-03-0173A</i>			17 INFORMANT Address <i>Albion L. Kilbreth 4004 Ogletrope St. Hyatt</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary artery insufficiency</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <i>Arteriosclerosis Heart Disease - Coronary Thrombosis</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Arteriosclerosis generalized</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>4 days</i> <i>4 days</i> <i>Undetermined</i>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <i>Carcinoma of Prostate</i>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from <i>July 13, 1968</i> , to <i>July 16, 1968</i> , that (I) (we) last saw the deceased alive on <i>July 15, 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Aaron H. Traum</i> M.D.						22c. DATE SIGNED <i>July 16, 1968</i>					
22d. PHYSICIAN'S NAME (Type) <i>Aaron H. Traum M.D.</i>						22e. ADDRESS <i>8237 Georgia Ave. Belton Springs Maryland</i>					
23a. BURIAL, CREMATION REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>July 19, 1968</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Geo. Wash. Mem. Cemetery</i>		23d. LOCATION (City or Town)		(County)		(State) <i>Hyattsville, Md.</i>	
24. FUNERAL DIRECTOR <i>J.W. Leffler</i> <i>Warner E. Pumphrey, Inc.</i>						25a. REC'D BY REGISTRAR <i>JUL 23 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit form. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH									
1. DECEASED NAME (Type or print) First Middle Last <i>Carol Jeanne M King</i>			2a. DATE OF DEATH Month Day Year <i>July 23 68</i>			2b. HOUR <i>5:12 P</i>			
3. SEX <i>F</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>9/1/20</i>		6. AGE (In years last birthday) <i>47</i> YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i> Md.			
10. CITY OR TOWN OF DEATH <i>Bethesda</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Ray-Rinchards</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>E.B.M.</i>			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <i>Maryland</i>		13b. COUNTY <i>Montgomery</i>		13c. CITY OR TOWN <i>Urbana</i>		13d. INSIDE CITY OR TOWN YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>17421 Park Mills Drive</i>	
14. FATHER'S NAME First Middle Last <i>Richard E. DuVal</i>			15. MOTHER'S M.A.D.E.N. NAME First Middle Last <i>Es Ther Frey</i>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO. <i>55213-129186</i>		17. INFORMANT <i>James L. King</i>		Address <i>52me 152nd</i>			
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Concussion</i> DUE TO, OR AS A CONSEQUENCE OF <i>Septicemia</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: <i>Subacute bacterial</i> DUE TO, OR AS A CONSEQUENCE OF <i>1 day</i> (c) <i>1 year</i>									
PART 2 - OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <i>Concussion</i>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM STREET FACTORY, OFFICE BUILDING ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (1) (this hospital) attended the deceased from <i>23 July 1968</i> , to <i>23 July 1968</i> , that (1) (we) last saw the deceased alive on <i>23 July 1968</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>STEVEN COLTWAY MD</i>				22c. DATE SIGNED <i>7-23-68</i>					
22d. PHYSICIAN'S NAME (Type) <i>STEVEN COLTWAY MD</i>				22e. ADDRESS <i>57010 FREDERICK CATHERSBURG, MD</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>7-26-68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>St. Peter & Paul</i>		23d. LOCATION (City or Town) (County) (State) <i>Cumtland, Md</i>			
24. FUNERAL DIRECTOR <i>Ernest C. Gartner, Catersburg, Md.</i>				25a. REC'D BY REGISTRAR <i>JUL 26 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The envelope remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

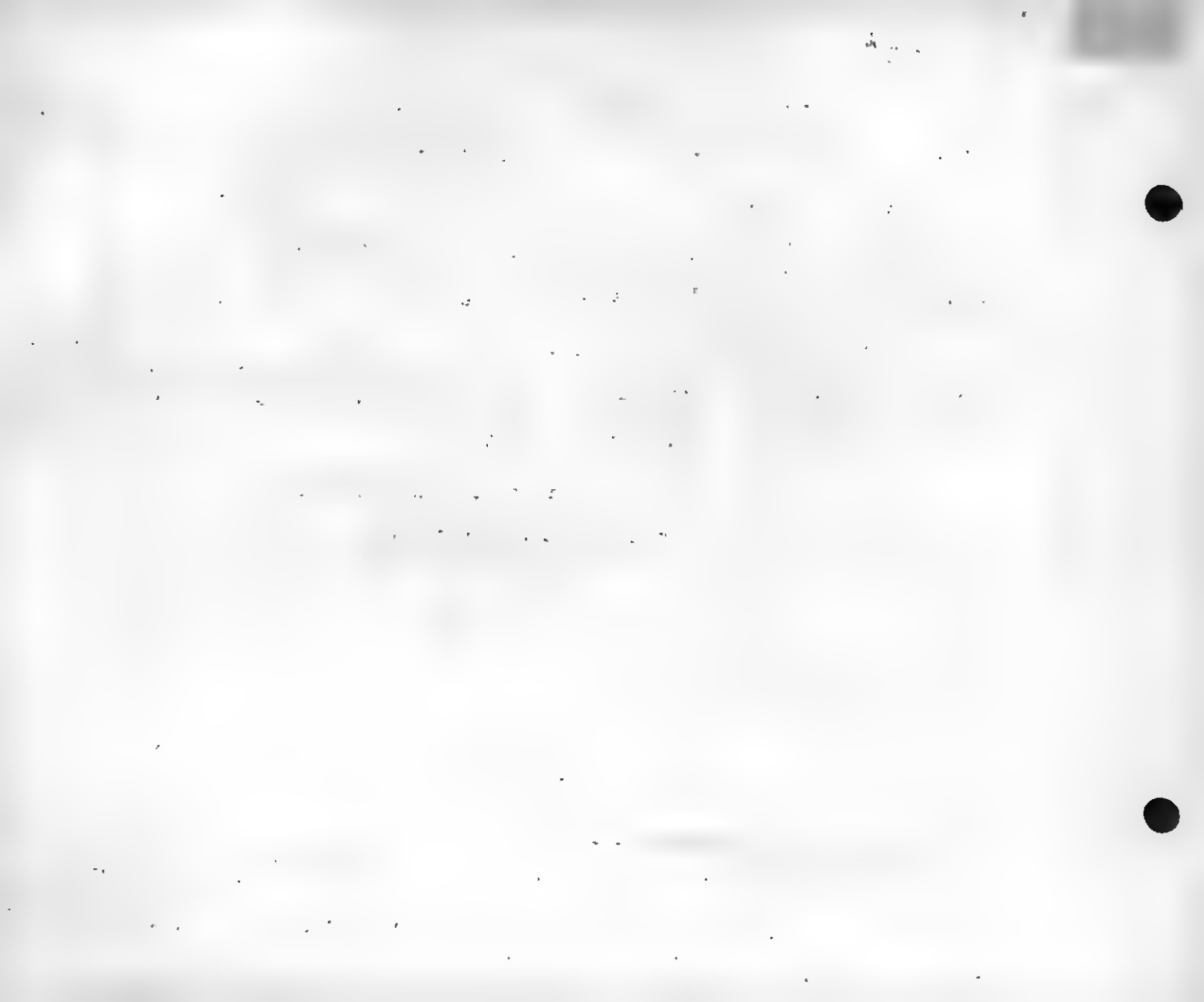
1. DECEASED NAME (Type or print) BESSIE GALLEHER KLINE			2a. DATE OF DEATH Month JULY Day 26 Year 1968			2b. HOUR 11 P M	
3 SEX FEMALE		4 RACE WHITE		5 DATE OF BIRTH 2/10/91		6 AGE (in years lost birthday) 77 YRS	
7a BIRTHPLACE (State or foreign country) MARYLAND		7b CITIZEN OF WHAT COUNTRY? U.S.A		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH MONTGOMERY Md	
10 CITY OR TOWN OF DEATH BETHESDA		11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) SUBURBAN		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) HOUSEWIFE		12b KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD.		13b. COUNTY MONT.		13c. CITY OR TOWN BETHESDA		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME First J. CLARK Middle GALLEHER Last LACY		15 MOTHER'S MAIDEN NAME First RICE Middle RICE Last RICE					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b SOCIAL SECURITY NO. 579-14-5428		17 INFORMANT HUSBAND (SETH KLINE) SAME AS ABOVE			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary insufficiency 4127 DUE TO, OR AS A CONSEQUENCE OF (b) severe coronary arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 42.1 (c) severe coronary arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Coronary arteriosclerosis							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 weeks
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC)		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from July 10, 1968 , to July 26, 1968 , that (I) (we) last saw the deceased alive on July 26, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Sidney J. Cohen, M.D.				DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED July 27, 1968	
22d. PHYSICIAN'S NAME (Type) Sidney J. Cohen, M.D.				22e. ADDRESS 50 W. 5th Street, Baltimore, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 7-29-68		23c. NAME OF CEMETERY OR CREMATORY Darnestown Church Cem.		23d. LOCATION (City or Town) (County) (State) Darnestown, Maryland	
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Maryland				25a. REC'D BY REGISTRAR JUL 31 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. (Page 4 and 5 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) Stuart Washburn Kneen, Jr.			2a. DATE OF DEATH Month July Day 11 Year 1968		2b. HOUR PM 11:59
3 SEX Male	4 RACE White	5 DATE OF BIRTH 21 February 1940		6 AGE (In years last birthday) 28 YRS.	IF UNDER 1 YEAR MONTHS DAYS
7a. BIRTHPLACE (State or foreign country) Vermont		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> D. VORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) The Clinical Center		9. COUNTY OF DEATH Montgomery Md.	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission). STATE Rhode Island		13b. COUNTY --		13c. CITY OR TOWN North Smithfield	
13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET AND NUMBER 147 Greenville Road			
14. FATHER'S NAME First Stuart Middle Washburn Last Kneen, Sr.			15. MOTHER'S MAIDEN NAME First Bernice Middle -- Last Kollanse		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) Yes (If yes give war or dates of service) 1957		16b. SOCIAL SECURITY NO. 030-30-3951		17. INFORMANT The Medical Records, The Clinical Center, Bethesda, Maryland 20014	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Intracerebral hemorrhage DUE TO, OR AS A CONSEQUENCE OF (b) Gram negative septicemia (Clinical) DUE TO, OR AS A CONSEQUENCE OF (c) Acute Lymphocytic Leukemia					APPROXIMATE INTERVAL, BETWEEN ONSET AND DEATH 12 hours 3 days 2 years
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, natly medical exam. nec)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State	
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 10 May , 19 68 , to 11 July , 19 68 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 11 July , 19 68 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death.					
22b. SIGNATURE Richard J. Samaha, M.D. DEGREE MD				22c. DATE SIGNED July 12, 1968	
22d. PHYSICIAN'S NAME (Type) Richard J. Samaha, M. D.		22e. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md. 20014			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 7/15/1968		23c. NAME OF CEMETERY OR CREMATORY WESTVIEW CEMETERY	
23d. LOCATION (City or Town) (County) (State) LEXINGTON, MASSACHUSETTS					
24. FUNERAL DIRECTOR William M. Hysong		25a. REC'D BY REGISTRAR JUL 15 1968		25b. REGISTRAR'S SIGNATURE J. Charles Judge	



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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) Robert L. KNIGHT				2a. DATE OF DEATH July Month 20 Day 68 Year			2b. HOUR 445P M		
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH Apr. 17, 1926			6. AGE (In years last birthday) 42 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Arizona		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.			
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Naval Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) U. S. Navy			12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE Maryland		13b. COUNTY Lexington Park		13c. CITY OR TOWN Lexington Park		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER Box 367	
14. FATHER'S NAME First Middle Last				15. MOTHER'S MAIDEN NAME First Middle Last					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown Yes				16b. SOCIAL SECURITY NO.		17. INFORMANT Address Park, Md. Mrs. Elizabeth L. Knight, Box 367, Lexington			
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metabolic acidosis 5710 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Hepatic and renal failure DUE TO, OR AS A CONSEQUENCE OF (c) Laennec's cirrhosis								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)			21f. LOCATION Street or R.F.D. No City or Town County State				
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from July 5, 1968 , to July 20, 1968 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on July 20, 1968 , and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) <input type="checkbox"/> (not) view the body after death.									
22b. SIGNATURE Charles S. Crummy DEGREE					ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>			22c. DATE SIGNED 22 July 68	
22d. PHYSICIAN'S NAME (Type) Charles S. Crummy, M. D.					22e. ADDRESS Naval Hospital, Bethesda, Maryland				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE JULY 24, 1968		23c. NAME OF CEMETERY OR CREMATORY Arlington National			23d. LOCATION (City or Town) (County) (State) Arlington, Virginia		
24. FUNERAL DIRECTOR Mattingly Funeral Home ADDRESS Leonardtown, Maryland					25a. REC'D BY REGISTRAR DATE JUL 23 1968		25b. REGISTRAR'S SIGNATURE Charles Judge		

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PH-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal and in any event within 72 hours after death.

1 DECEASED NAME (Type or Print) Warren Steele Koontz			2a DATE KNOWN OF DEATH MATED Month Day Year July 8 1968			2b HOUR 5:30 AM		
3 SEX M.	4 RACE W.	5 DATE OF BIRTH May 22 1915	6 AGE (In years last birthday) 53 YRS	7 UNDER 1 YEAR MONTHS DAYS	7 UNDER 24 HRS HOURS MIN	2c DATE PRONOUNCED DEAD Month Day Year July 8 1968		
7a BIRTHPLACE (State or foreign country) Maryland		7b CIT ZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Montgomery Md		
10 CITY OR TOWN OF DEATH Wheaton		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 11536 Highview Ave		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Engineer, Navy Dept of Defense		12b KIND OF BUSINESS OR INDUSTRY		
13a USUAL RESIDENCE (Where deceased lived, if institution admission) STATE Md.		13b COUNTY Montgomery		13c CITY OR TOWN Wheaton		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 11536 Highview Ave
14 FATHER'S NAME First Middle Last Wilbur Lewis Koontz			15 MOTHER'S MAIDEN NAME First Middle Last Zola N. Streaker					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknown) yes			16b SOCIAL SECURITY NO (If yes give war or dates of service) 11 0422-16-7724		17 INFORMANT ADDRESS 11536 Highview Ave, Wheaton, Md. Virginia C. Koontz			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4317 Hemorrhage Intra Cerebral Bilateral Massive 3hr. DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) Generalized Arterio Sclerosis DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH years.								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21a INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21b PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No		City or Town		County State
22a I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE EXAMINER'S NAME (Type) John S. Bell		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county) John S. Bell, Bethesda, Md.		22b DATE SIGNED July 8, 1968				
23a BURIAL, CREMATION REMOVAL (Specify)		23b DATE July 10, 1968		23c NAME OF CEMETERY OR CREMATORY Park Lawn Cemetery		23d LOCATION (City or Town) (County) (State) Rockville, Maryland		
24 FUNERAL DIRECTOR Charles J. Humphrey, Inc. 8474 Georgia Ave. Silver Spring, Maryland				25a REC'D BY REGISTRAR JUL 12 1968		25b REGISTRAR'S SIGNATURE Charles Judge		

CA.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
30M REV 1-68

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1 DECEASED NAME (Type or print) <i>William</i>			First <i>William</i> Middle <i>J</i> Last <i>Lackland</i>			2a DATE OF DEATH Month <i>July</i> Day <i>27</i> Year <i>1968</i>		2b HOUR <i>7:00 A.M.</i>	
3 SEX <i>Male</i>		4 RACE <i>White</i>		5 DATE OF BIRTH <i>March 11, 1884</i>		6 AGE (In years last birthday) <i>84</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
7a BIRTHPLACE (State or foreign country) <i>Illinois</i>		7b CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <i>Montgomery</i> Md.			
10 CITY OR TOWN OF DEATH <i>Silver Spring</i>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>7809 Boston Avenue</i>		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Retired Insurance Agency Employee</i>		12b KIND OF BUSINESS OR INDUSTRY <i>Self Employed</i>			
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md.</i>		13b COUNTY <i>Montgomery</i>		13c CITY OR TOWN <i>Silver Sp.</i>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER <i>7809 Boston Avenue</i>	
14 FATHER'S NAME First <i>Malvin</i> Middle <i>Lackland</i> Last <i>Edith</i>			15 MOTHER'S MAIDEN NAME First <i>Edith</i> Middle <i>Jayner</i> Last <i>Jayner</i>						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes, give war or dates of service)		16b SOCIAL SECURITY NO <i>579-01-9883 A</i>		17 INFORMANT <i>Mrs. Hazel E. Lackland</i>		17a ADDRESS <i>7809 Boston Ave. Silver Spring, Md.</i>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Thrombosis</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Arteriosclerosis</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Cardiac Decompensation</i>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Cardiac Decompensation</i>									
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <i>1950 to 27 Aug. 1968</i> , that (I) (we) last saw the deceased alive on <i>26 Aug. 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>William D. And</i>		22c. DATE SIGNED <i>7/27/68</i>		22d. PHYSICIAN'S NAME (Type) <i>William D. And</i>		22e. ADDRESS <i>9006 Colesville Rd., Silver Spring, Md.</i>			
23a BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>July 31, 1968</i>		23c NAME OF CEMETERY OR CREMATORY <i>Parklawn Cemetery</i>		23d LOCATION (City or Town) (County) (State) <i>Rockville, Maryland</i>			
24. FUNERAL DIRECTOR <i>Wanner E. Pumphrey, Inc.</i>		24a ADDRESS <i>8434 Georgia Ave. Silver Spring, Md.</i>		25a REC'D BY REGISTRAR DATE <i>AUG 2 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

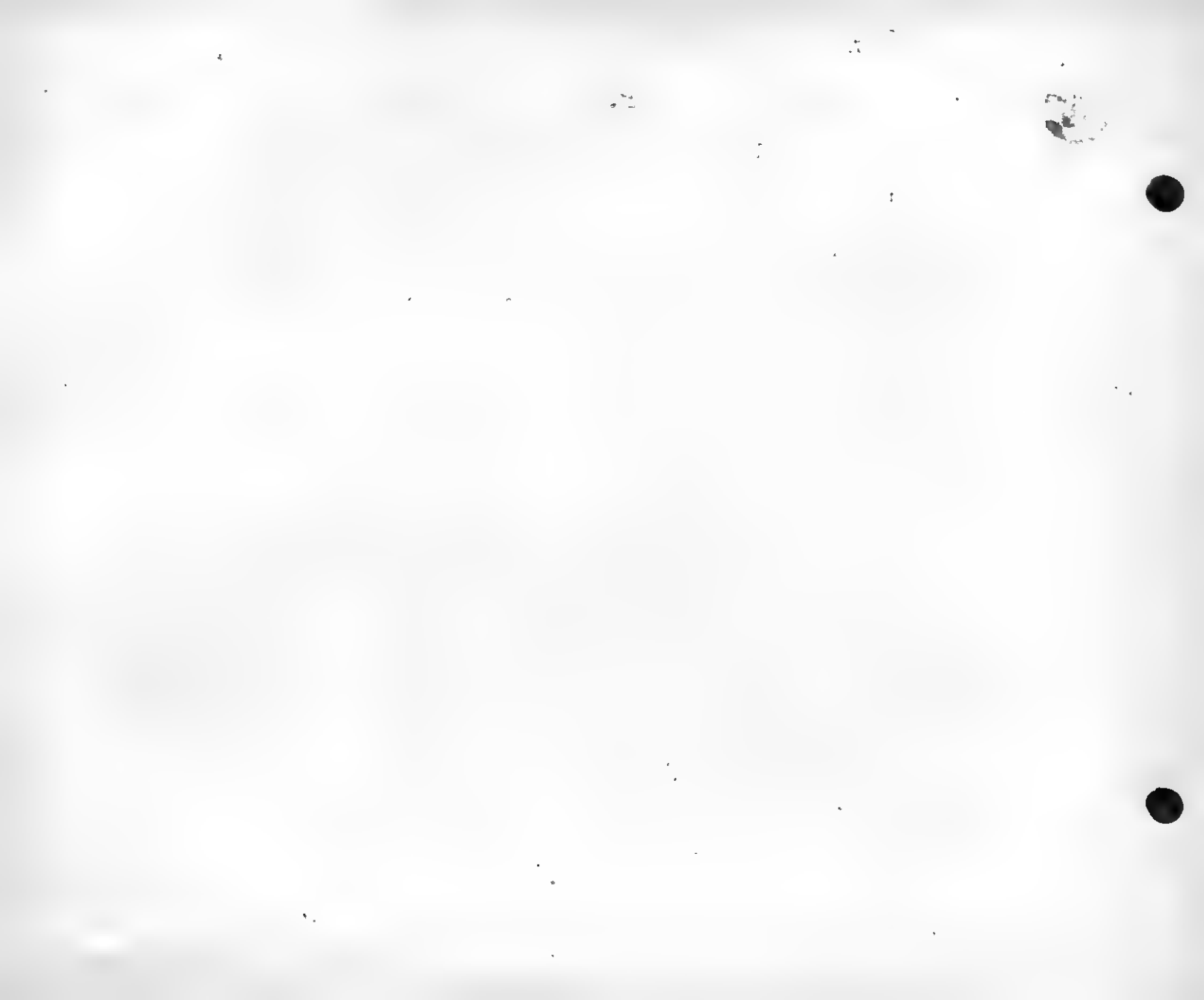
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 18 & 22a Film 403 MARYLAND STATE DEPARTMENT OF HEALTH
8-14-68 ams DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10251

1. DECEASED NAME First Middle Last ANNA La Fourcade		2a. DATE KNOWN OF DEATH Month Day Year 7/17/1968		2b. HOUR 6 PM
3. SEX Fe.	4. RACE wh	5. DATE OF BIRTH 11/9/86	6. AGE (In years last birthday) 81 YRS	7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH Silver Spring,		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Holy Cross Hospital		9. COUNTY OF DEATH Montgomery
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Md		13b. COUNTY Montgomery Tak. Park	13c. CITY OR TOWN Tak. Park	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME First Middle Last HENRY R. DWYER		15. MOTHER'S MAIDEN NAME First Middle Last HARRIETT SAGE		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO
16b. SOCIAL SECURITY NO 579-05-7414		17. INFORMANT THELMA BOLLMAN		17a. ADDRESS 109 ELM AVE TAKOMA PARK
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))				
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Extrinsic obstruction of sigmoid colon 616.1 DUE TO, OR AS A CONSEQUENCE OF (b) due to peritoneal - left ovarian adhesions DUE TO, OR AS A CONSEQUENCE OF (c)				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)
21d. NATURE OF INJURY WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No City or Town County State
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: <input checked="" type="checkbox"/> Natural causes <input type="checkbox"/> Accidental <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				
ACTUAL SIGNATURE Belden R. Kepp		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED July 18, 1968
EXAMINER'S NAME (Type) BELDEN R. KEPP M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22c. ADDRESS (Street, City, County) Washington, D.C.
23a. BURIAL OR CREMATION Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/>		23b. DATE July 22, 1968		23c. NAME OF CEMETERY OR CREMATORY GLENWOOD CEMETERY
23d. LOCATION (City or Town) (County) (State) WASHINGTON D.C.		23e. REC'D BY REG. STRAR JUL 22 1968		23f. REG. STRAR'S SIGNATURE Charles Judge
24. FUNERAL DIRECTOR Arthur Walters		24a. ADDRESS 154 Carroll St		24b. CITY OR TOWN Washington, D.C.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper at pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201															
CERTIFICATE OF DEATH (July 11, 1968)															
1. DECEASED-NAME (Type or print) VERA Edwards			2a. DATE OF DEATH Month XX Day XX Year XX			2b. HOUR 2 PM									
3 SEX Female		4. RACE White		5. DATE OF BIRTH 10/4/1893		6 AGE (In years last birthday) 74 YRS.		F UNDER 1 YEAR MONTHS DAYS		H UNDER 24 HRS. HOURS M.N.					
7a BIRTHPLACE (State or foreign country) Md.		7b CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery									
10. CITY OR TOWN OF DEATH Bethesda			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) GROSVENOR			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Homemaker			12b. KIND OF BUSINESS OR INDUSTRY						
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE Md.		13b. COUNTY SALOME		13c. CITY OR TOWN Bethesda		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 5427 Lincoln St							
14. FATHER'S NAME First DANIEL Middle EDWARDS Last HENRIETTA			15. MOTHER'S MAIDEN NAME First Smith Middle Smith Last Smith			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give year or dates of service) No						16b. SOCIAL SECURITY NO 578-48-3240		17. INFORMANT Mr. George W. Laird, Bethesda, Md.	
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebrovascular Accident, multiple DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerosis, generalised, advanced DUE TO, OR AS A CONSEQUENCE OF (c) Hypertension, severe chronic										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 1/2 hrs					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Cerebrovascular accidents, multiple during past 6 yrs.															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State											
22a. I certify that (I) (this hospital) attended the deceased from 1948 , to July 11, 1968 , that (I) (we) lost saw the deceased alive on July 11, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (not) view the body after death.															
22b. SIGNATURE Stewart Clapp M.D.		22c. DATE SIGNED July 11 1968		22d. PHYSICIAN'S NAME (Type) Stewart Clapp M.D.											
22e. ADDRESS 4740 Chevy Chase Dr. Chevy Chase 15 Md.															
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 7/15/68		23c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery		23d. LOCATION (City or Town) (County) (State) Rockville, Montg. Md.									
24. FUNERAL DIRECTOR Robert A. Pumphrey, Bethesda, Maryland		7557 ADDRESS Wisconsin Ave.		REC'D BY REGISTRAR JUL 16 1968		25b. REGISTRAR'S SIGNATURE Charles Judge									



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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
CERTIFICATE OF DEATH												
1. DECEASED-NAME (Type or print) First Middle Last FREDERICK W. LANG						2a. DATE OF DEATH Month Day Year 7 10 1968			2b. HOUR 845 P.M.			
3. SEX Male		4. RACE White		5. DATE OF BIRTH 5-21-1890			6. AGE (In years last birthday) 78 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) England		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.						
10. CITY OR TOWN OF DEATH Kensington - Md.			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Kensington Garden San.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Cosmetologist			12b. KIND OF BUSINESS OR INDUSTRY SELF-EMPLOYED			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE 4108 Everett St. Kensington, Md.			13b. COUNTY MONT.			13c. CITY OR TOWN Kensington		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 4108 Everett St.		
14. FATHER'S NAME First Middle Last Geo. - Lang						15. MOTHER'S MAIDEN NAME First Middle Last Louise Kolb						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No (If yes give war or dates of service) ****				16b. SOCIAL SECURITY NO. 082-07-0915		17. INFORMANT Mrs. Evelyn T. Lang, Kensington, Md.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Embolus DUE TO, OR AS A CONSEQUENCE OF: (b) Thrombosis Left Atricle DUE TO, OR AS A CONSEQUENCE OF: (c) Auricular Fibrillation										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 1/2 hrs ? 10 yrs		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Aortic Insufficiency with cardiomegaly.												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)								
21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office, building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State								
22a. I certify that (I) (this hospital) attended the deceased from 1948 , to July 10, 1968 , that (I) (we) last saw the deceased alive on July 10, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death.												
22b. SIGNATURE Stewart Clapp MD DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>						22c. DATE SIGNED 7/10/68						
22d. PHYSICIAN'S NAME (Type) Stewart Clapp MD		22e. ADDRESS 4140 Chevy Chase Dr. Chevy Chase, Md.										
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 7/15/68		23c. NAME OF CEMETERY OR CREMATORY FAIRMONT CEMETERY				23d. LOCATION (City or Town) (County) (State) NEWARK, N. J.				
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Md.				455 Wisconsin Ave. REC'D BY REGISTRAR JUL 16 1968				25b. REGISTRAR'S SIGNATURE f Charles Judge				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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CLEAR WITH CORNER, R. JOHN G. BALL

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
20254
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) BETHESDA c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTG c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) BETHESDA d. STREET ADDRESS 5712 KINGSWOOD RD e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First NELLIE Middle FAY Last LEGERE		4. DATE OF DEATH Month JULY Day 8 Year 1968	
5. SEX FEMALE		6. COLOR OR RACE WHITE	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH MAY 12 1988	
9. AGE (In years last birthday) 80 yrs.		10. IF UNDER 1 YEAR Months 8 Days 11 Hours 15 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CAFETERIA WORKER		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) BRIDGEPORT CONN		12. CITIZEN OF WHAT COUNTRY? AMERICA	
13. FATHER'S NAME PATRICK FAY		14. MOTHER'S MAIDEN NAME ELLEN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. (If yes give war or dates of service)	
17. INFORMANT NO		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) VENTRICULAR FIBRILLATION + 100% Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) CORONARY SCLEROSIS DUE TO (c) ARTERIOSCLEROTIC HEART DISEASE PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH AT ONCE 10 YEARS 10 YEARS	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from MAY 26 1967 to JULY 8 1968 , that (I) (we) last saw the deceased alive on APRIL 24 1968 , and that death occurred at 2:30 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Robert E. Angle		22b. DATE SIGNED JULY 8 1968	
22c. PHYSICIAN'S NAME (Type) Robert E. Angle		22d. ADDRESS 5009 Del Ray Ave. Bethesda Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF July 11 1968	
23c. NAME OF CEMETERY OR CREMATORY Rockville Union		23d. LOCATION (City, town or county) (State) Rockville Mont. Md.	
24. FUNERAL DIRECTOR Robert A. Pumphrey		25a. REC'D BY REGISTRAR JUL 11 1968	
25b. REGISTRAR'S SIGNATURE J. Charles Judge			



FOR STATE
HEALTH DEPT.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED NAME (Type or Print)			First Middle Last			2a DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> Month Day Year			2b HOUR		
Morris I. Lewis						7 17 1968			9 AM		
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		2c DATE PRONOUNCED DEAD Month Day Year			2d HOUR
Male	White	2/2/00	68 YRS					7 17 1968			9 AM
7a BIRTHPLACE (State or foreign country)			7b CITIZEN OF WHAT COUNTRY?			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH		
Russia			USA						Montgomery Md		
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of work life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY		
Sil. S. rg Md.			Holy Cross Hospital			owner drugstore			drug store		
13a USUAL RESIDENCE (Where deceased lived, if institution on Residence before admission) STATE			13b COUNTY			13c CITY OR TOWN			13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
Maryland			Montgomery			SS			13e STREET AND NUMBER		
									11616 Lockwood Drive		
14. FATHER'S NAME First Middle Last			15 MOTHER'S MAIDEN NAME First Middle Last								
Noah ? Lewis			Sarah ? 2/								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SECURITY NO.			17 INFORMANT ADDRESS					
no						wife Grace 11616 Lockwood Dr SS Md.					
18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Insufficiency</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <u>Coronary Artery Heart Disease</u> (b) <u>Coronary Artery Heart Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Pulmonary Emphysema</u>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that I took charge of the remains described above held in Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>Belden R. Read</u>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			22b DATE SIGNED <u>July 17, 1968</u>		
EXAMINER'S NAME (Type) <u>BELDEN R. READ, M.D.</u>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			ADDRESS (Type or Print) <u>13501-14th St NW</u>					
23a BURIAL, CREMATION, REMOVAL (Specify)			23b DATE			23c NAME OF CEMETERY OR CREMATORY			23d LOCATION (City or Town) (County) (State)		
Burial			JULY 19, 1968			MT. HEBRON CEMETERY			FLUSHING L.I. N.Y.		
24 FUNERAL DIRECTOR <u>13501-14th St NW</u>			ADDRESS			25a REC'D BY REGISTRAR DATE <u>JUL 22 1968</u>			25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>		



CERTIFICATE OF DEATH

100556

10266

1 DECEASED NAME (Type or print) WERNER		First Middle Last		2a. DATE OF DEATH 7 Month 11 Day 68 Year		2b. HOUR 1230 A M	
3 SEX Male		4. RACE white		5. DATE OF BIRTH 4-13-18		6 AGE (In years lost birthday) 50 YRS.	
7a. BIRTHPLACE (State or foreign country) Germany		7b. CITIZEN OF WHAT COUNTRY? U.S.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.	
10 CITY OR TOWN OF DEATH Takoma Park		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington Sanitarium		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Industrial Engineer		12b. KIND OF BUSINESS OR INDUSTRY	
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland		13b. COUNTY Montgomery		13c CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e STREET AND NUMBER 815 Gregorio Drive		14. FATHER'S NAME First Middle Last Abraham - Lilienthal		15. MOTHER'S MAIDEN NAME First Middle Last Frida Dietrich		16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No	
16b SOCIAL SECURITY NO. 279-26-9514		17 INFORMANT JULIA LILIENTHAL		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Myocardial Infarction 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 4201							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State		22a. I certify that (I) (this hospital) attended the deceased from Feb , 19 67 , to July 4 , 19 68 , that (I) (we) last saw the deceased alive on July 11 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.	
22b. SIGNATURE Boris Rabkin MD		22c. DATE SIGNED 7-11-68		22d. PHYSICIAN'S NAME (Type) BORIS RABKIN MD		22e. ADDRESS 1019 Union Blvd East	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE July 12, 1968		23c. NAME OF CEMETERY OR CREMATORY King David Memorial Garden		23d. LOCATION (City or Town) (County) (State) Falls Church, Virginia	
24. FUNERAL DIRECTOR Donald M. Stein		ADDRESS 232 Carroll		25a. REC'D BY REGISTRAR JUL 15 1968		25b. REGISTRAR'S SIGNATURE J Charles Judge	
HEBREW MEMORIAL FUNERAL HOME ST. N.W. WASH., D.C.							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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Cleared by Dr. Reed

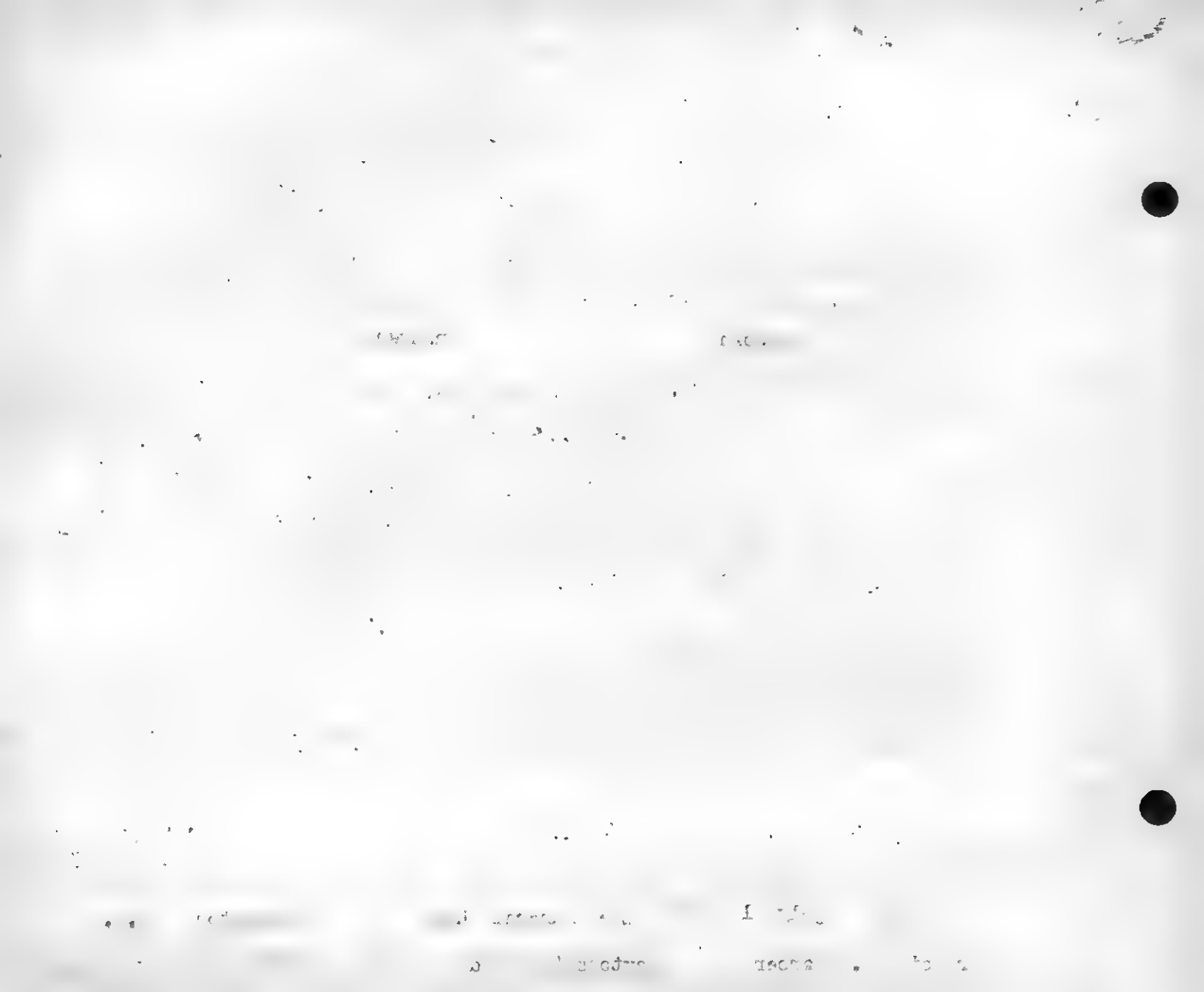
MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1 DECEASED NAME (Type or print) Sarah Christene Londeree						2a. DATE OF DEATH Month 7 Day 17 Year 68		2b. HOUR 1:05 AM		
3 SEX Female		4 RACE White		5. DATE OF BIRTH 8-31-92		6. AGE (In years lost birthday) 75 YRS		IF UNDER 1 YEAR MONTHS IF UNDER 24 HRS DAYS HOURS MIN		
7a. BIRTHPLACE (State or foreign country) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md				
10. CITY OR TOWN OF DEATH Silver Spring			11. NAME OF HOSPITAL, OR INSTITUTION (If not in hospital give street address) Holy Cross Hosp.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife		12b. KIND OF BUSINESS OR INDUSTRY OWN HOME		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Montgomery		13c. CITY OR TOWN Sil. Spr.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 12108 Edgemont St.	
14. FATHER'S NAME First Walker Middle W. Last White			15. MOTHER'S MAIDEN NAME First May Middle Sue Last Page			16. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No (If yes give year or dates of service)				
16b. SOCIAL SECURITY NO 227-36-7735			17. INFORMANT Virginia C. Parker (Dau)			Address Bethesda, Md. 6003 Roosevelt St.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pro. Bow marker Failure										
4129 DUE TO, OR AS A CONSEQUENCE OF										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										
(b) Acute Stroke Syndrome										
DUE TO, OR AS A CONSEQUENCE OF										
(c) A.S.C.U.D.										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
4										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE J.C. De Gunnan		22c. DATE SIGNED 7-17-68		22d. PHYSICIAN'S NAME (Type) J.C. De Gunnan		22e. ADDRESS 1234 19 NW Wash DC.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Funeral		23b. DATE July 20, 1968		23c. NAME OF CEMETERY OR CREMATORY Spring Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Lynchburg Virginia				
24. FUNERAL DIRECTOR Warner E. Pumphrey Inc.		ADDRESS 8434 Ga/ Ave. S.S., Md.		25a. RECD BY REGISTRAR JUL 23 1968		25b. REGISTRAR'S SIGNATURE Charles Judge				



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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1 DECEASED NAME (Type or print) First Middle Last Mabel Louise Lucas						2a. DATE OF DEATH Month Day Year July 16 1968			2b. HOUR 7 ⁵ P.M.		
3. SEX Female		4 RACE White		5 DATE OF BIRTH Feb 15 th - 1883		6 AGE (In years last birthday) 85 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) England		7b. CITIZEN OF WHAT COUNTRY? U.S.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Montgomery Md					
10. CITY OR TOWN OF DEATH Olney		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Brooke Grove Nursing Home				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Cosmetician			12b. KIND OF BUSINESS OR INDUSTRY Cosmetology		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Prince George's		13c. CITY OR TOWN Riverdale		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 6300 - 59 th Ave.			
14. FATHER'S NAME First Middle Last Unknown				15 MOTHER'S MAIDEN NAME First Middle Last Unknown							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) No		16b. SOCIAL SECURITY NO. 578-09-4853		17 INFORMANT Mrs. William Jones				Address 6300 - 59 th Ave. - Riverdale, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>BASILAR ARTERY THROMBOSIS</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>CEREBRAL ARTERIOSCLEROSIS</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>GENERAL ARTERIOSCLEROSIS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>SENILITY - BRAIN SYNDROME</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from <u>12/31</u> , 19 <u>64</u> , to <u>7-16</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>7-12</u> , 19 <u>68</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death											
22b. SIGNATURE Donald R. Lewis MD		DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED July 16 68	
22d. PHYSICIAN'S NAME (Type) DONALD R. LEWIS		22e. ADDRESS 700 CLOVERLY		22f. ADDRESS SILVER SPRING, MD							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE July 18 1968		23c. NAME OF CEMETERY OR CREMATORY Lee Funeral Home		23d. LOCATION (City or Town) Washington		(County) D.C.		(State)	
24. FUNERAL DIRECTOR Francis H. Barber				ADDRESS Laytonsville Md		25a. RECD. BY REGISTRAR DATE JUL 23 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			



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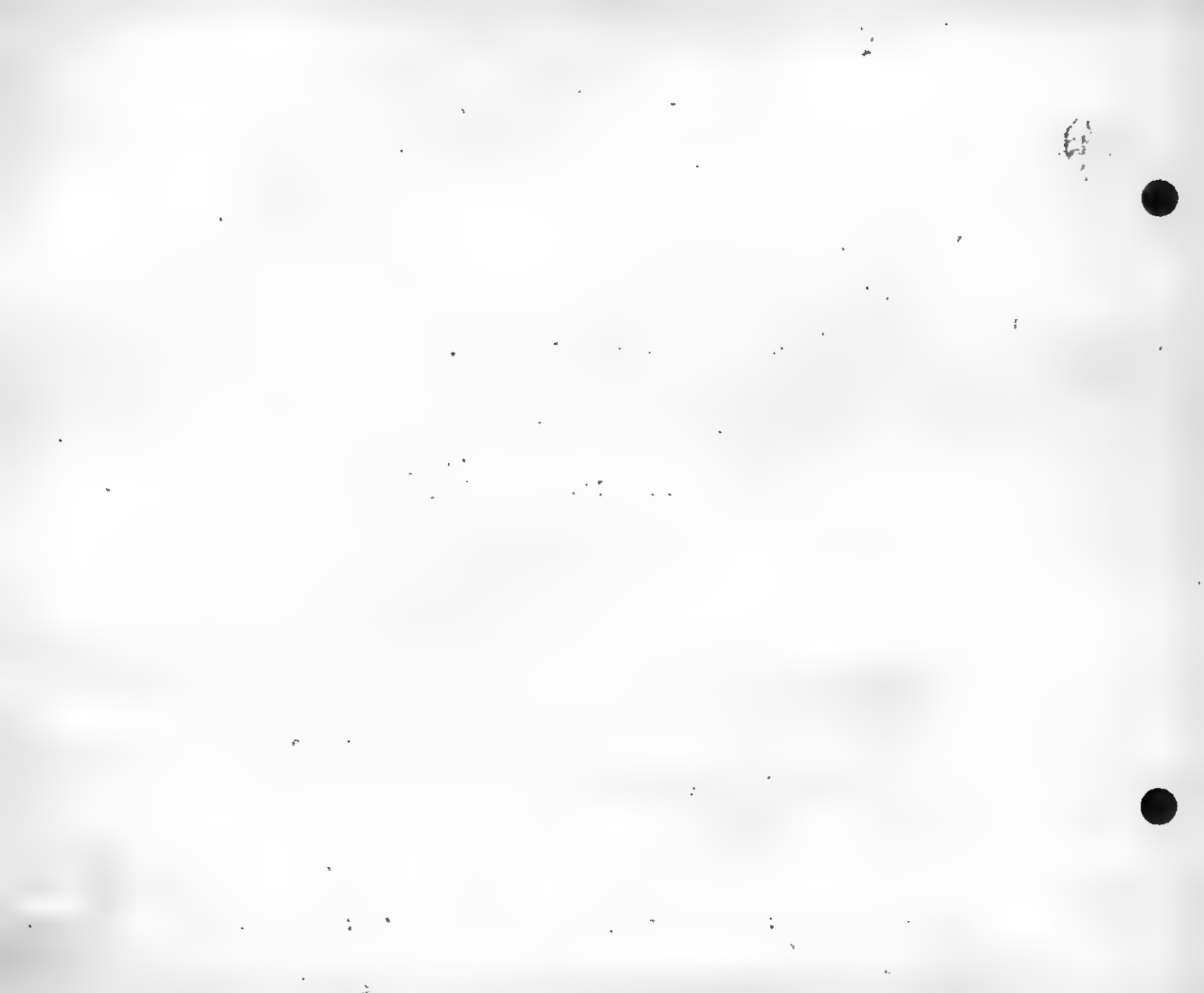
MIDDLE										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
10259										CERTIFICATE OF DEATH									
1 DECEASED NAME (Type or print) First Middle Last Antonio L. LUCCI										2a DATE OF DEATH Month Day Year 7 19 68									
3 SEX MALE										4 RACE White									
5 DATE OF BIRTH 3/26/89										6 AGE (In years last birthday) 79 YRS.									
7a BIRTHPLACE (State or foreign country) Italy										7b CITIZEN OF WHAT COUNTRY? U.S.A.									
8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										9. COUNTY OF DEATH Montgomery Md.									
10 CITY OR TOWN OF DEATH Silver Spring, Md.										11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Holy Cross									
12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Stone Mason										12b KIND OF BUSINESS OR INDUSTRY Siesta Co.									
13a USJA. RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.										13b. COUNTY MONT									
13c CITY OR TOWN SILVER SPRING										13d INSIDE CITY, YES <input type="checkbox"/> NO <input type="checkbox"/>									
13e STREET AND NUMBER 1007 NORA DRIVE																			
14 FATHER'S NAME First Middle Last Ruffino Lucci										15. MOTHER'S MAIDEN NAME First Middle Last Anna Grace									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) No										16b SOCIAL SECURITY NO. 185-10-0192									
17 INFORMANT Dionens Lucci										1007 Nora Drive Silver Spring, Md.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of stomach DUE TO, OR AS A CONSEQUENCE OF (b) CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) 1519										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 1/2 years									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)																			
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED									
20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19									
21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)																			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)									
21f. LOCATION Street or R.F.D. No. City or Town County State																			
22a. I certify that (I) (the hospital) attended the deceased from April , 19 66 , to 7-19 , 19 68 , that (I) (we) last saw the deceased alive on 7-19 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																			
22b. SIGNATURE Jason Becker, M.D.										22c. DATE SIGNED 7-19-68									
22d. PHYSICIAN'S NAME (Type) JASON BECKER, M.D.										22e. ADDRESS 800 PERSHING DRIVE SILVER SPRING, MD.									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial										23b. DATE July 23, 1968									
23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven										23d. LOCATION (City or Town) (County) (State) Silver Spring, Md.									
24. FUNERAL HOME C. Glen Carter Warner E. Pumphrey, Inc.										25. REG. STRA'S SIGNATURE Charles Judge									
25a. REC'D BY REGISTRAR JUL 25 1968										25b. DATE									



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MARYLAND STATE DEPARTMENT OF HEALTH												
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
CERTIFICATE OF DEATH												
1. DECEASED NAME (Type or print) Grace S. Lyles						2a. DATE OF DEATH Month July Day 19 Year 68			2b. HOUR 4:45 PM			
3. SEX Female		4. RACE Negro		5. DATE OF BIRTH Sept 29, 1900			6. AGE (in years last birthday) 67 YRS.		IF UNDER YEAR MONTHS DAYS 		IF UNDER 24 HRS HOURS MIN 	
7a. BIRTHPLACE (State or foreign country) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md						
10. CITY OR TOWN OF DEATH Damascus			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 4501 Holsley Road			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.			13b. COUNTY Montg		13c. CITY OR TOWN Damascus		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER Holsley Road			
14. FATHER'S NAME First William Middle Simms Last 				15. MOTHER'S MAIDEN NAME First Bessie Middle Woods Last 								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown				16b. SOCIAL SECURITY NO. 219-65-2394A		17. INFORMANT Address						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Atherosclerotic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF Diabetes mellitus Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO, OR AS A CONSEQUENCE OF (c) 										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 years 6 years		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 422												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State								
22a. I certify that (I) (this hospital) attended the deceased from 6/15 , 19 65 to 7/19 , 19 68 , that (I) <input checked="" type="checkbox"/> saw the deceased alive on 7/19 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> (we) <input type="checkbox"/> (did) <input type="checkbox"/> view the body after death.												
22b. SIGNATURE James P. Kerr M.D. DEGREE M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 7/26/68				
22d. PHYSICIAN'S NAME (Type) JAMES P. KERR M.D.						22e. ADDRESS DAMASCUS, MD						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 7-24-68		23c. NAME OF CEMETERY OR CREMATORY Friendship Ch. Cem.		23d. LOCATION (City or Town) (County) (State) DAMASCUS Montg Md.						
24. FUNERAL DIRECTOR Robert L. Snowden				ADDRESS Kecoville Md.		25a. REC'D BY REGISTRAR DATE JUL 25 1968		25b. REGISTRAR'S SIGNATURE Johnas Judge				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, full and complete funeral arrangements should be made. The funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1, and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) EDNA STANLEY MACDONALD			2a DATE OF DEATH Month July Day 10 Year 68			2b HOUR 9:25 AM			
3 SEX F		4 RACE Wh.		5 DATE OF BIRTH March 2, 1976		6 AGE (In years last birthday) 92 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. 	
7a BIRTHPLACE (State or foreign country) Kentucky		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.			
10 CITY OR TOWN OF DEATH Silver Spring		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Holy Cross Hosp.			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) None			12b KIND OF BUSINESS OR INDUSTRY None	
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MD COUNTY Montgomery		13b CITY OR TOWN Silver Spring		13c INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 601 Maple St.			
14 FATHER'S NAME First Unknown Middle Last 			15. MOTHER'S MAIDEN NAME First Unknown Middle Last 						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> or unknown <input type="checkbox"/>		16b SOCIAL SECURITY NO. 277-03-8115-4		17 INFORMANT Mr. Thomas Boardman Address 10710 Holbrook Dr. Silver Spring, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Branched pneumonia DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Fracture of hip DUE TO, OR AS A CONSEQUENCE OF (c) senility								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days 5 days	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 491X									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year 19 P.M. 		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State 					
22a. I certify that (I) (this hospital) attended the deceased from , 19 , to , 19 , that (I) (we) last saw the deceased alive on , 19 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Jerry Farber, MD				DEGREE MD		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 7-10-68	
22d. PHYSICIAN'S NAME (Type) JERRY FARBER				22e. ADDRESS 8812 CAMERON ST SILVER SPRING MD MONTGOMERY					
23a. BURIAL, CREMATION, REMOVAL (Specify) Interment		23b. DATE 7/11/68		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill		23d. LOCATION (City or Town) (County) (State) Prince George's, Md.			
24. FUNERAL DIRECTOR Rockville				25a. RECORDED BY REGISTRAR JUL 15 1968		25b. REGISTRAR'S SIGNATURE J. Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

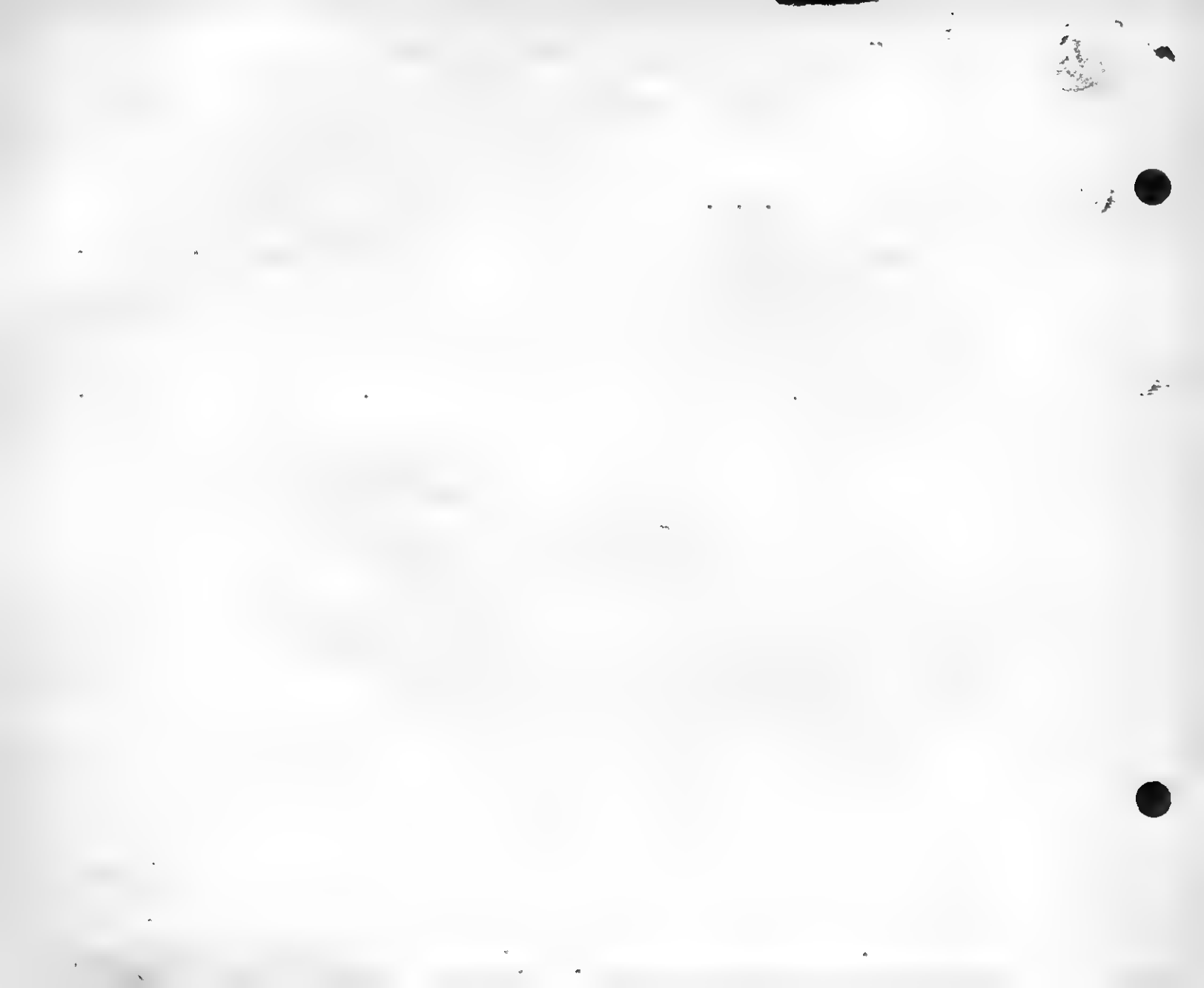
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print) <i>Mary Veronica Maher</i>			2a DATE OF DEATH Month <i>July</i> Day <i>26</i> Year <i>1968</i>			2b HOUR <i>4:45</i> M					
3. SEX <i>Female</i>		4. RACE <i>white</i>		5. DATE OF BIRTH <i>12-25-85</i>		6 AGE (In years last birthday) <i>82</i> YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN	
7a BIRTHPLACE (State or foreign country) <i>New York State</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Madison</i> Md.					
10. CITY OR TOWN OF DEATH <i>Bethesda</i>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban</i>		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Retired Nurse</i>		12b KIND OF BUSINESS OR INDUSTRY					
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Maryland</i> COUNTY <i>Montgomery</i>		13b CITY OR TOWN <i>Bethesda</i>		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER <i>6228 Lane Oak Drive</i>					
14. FATHER'S NAME <i>Thomas</i>		15. MOTHER'S MAIDEN NAME <i>Catherine</i>		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)							
16b SOCIAL SECURITY NO <i>5817</i>		17 INFORMANT <i>Lucy B. Maher - daughter-in-law</i>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>STROKE</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>HYPERTENSION & ARTERIOSCLEROSIS</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>3 DAYS</i> 3 YRS							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, not by medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from <i>JULY 1960</i> , to <i>JULY 1968</i> , that (I) (we) last saw the deceased alive on <i>JULY 26 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Leo I. Donovan</i>		DEGREE <i>DR LEO I DONOVAN</i>		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>7/26/68</i>					
22d. PHYSICIAN'S NAME (Type) <i>DR LEO I DONOVAN</i>		22e. ADDRESS <i>8218 WISCONSIN AVE</i>									
23a. BURIAL, CREMATION, OR REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>7-29-68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>St. Mary's</i>		23d. LOCATION (City or Town) <i>Queens</i>		(County)		(State) <i>N.Y.</i>	
24. FUNERAL DIRECTOR <i>Joseph Gauder's Sons</i>		ADDRESS <i>513 WISC. AVE. N.W.</i>		25a. REC'D BY REGISTRAR <i>Charles Judge</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					
DATE <i>JUL 31 1968</i>											

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 4 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARTLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print) Leonard SYLVESTER Marino						2a. DATE OF DEATH Month July Day 17 Year 1968			2b. HOUR 7:54 M		
3. SEX male		4. RACE W.		5. DATE OF BIRTH July 17, 1891		6. AGE (In years lost birthday) 77 YRS.		IF UNDER 1 YEAR MONTHS 0 DAYS 0		IF UNDER 24 HRS. HOURS 0 MIN 0	
7a. BIRTHPLACE (State or foreign country) Italy		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.					
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Suburban		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Construction Eng.				12b. KIND OF BUSINESS OR INDUSTRY Bldg.			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Mont		13c. CITY OR TOWN Bethesda		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 10630 Kenilworth Ave			
14. FATHER'S NAME First FRANK Middle MARINO Last Celestina Buonatti				15. MOTHER'S MAIDEN NAME First Celestina Middle Buonatti Last Buonatti							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) yes (If yes give war or dates of service) W.W.I.		16b. SOCIAL SECURITY NO. 097-07-8989		17. INFORMANT Leonard P. Marino				Address Bethesda, Md/			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) cardiovascular collapse 4100 DUE TO, OR AS A CONSEQUENCE OF (b) acute myocardial infarction Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause (c) arteriosclerotic hypertension - moderate 5 yrs. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 4201										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 hours	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (A) (this hospital) attended the deceased from July 12, 1968 to July 17, 1968 , that (B) (we) lost saw the deceased alive on July 12, 1968 , and that (C) (my) (our) opinion of death occurred on the date and hour and from the causes stated above. (B) (we) (d) (d) (not) view the body after death.											
22b. SIGNATURE Wilfred R. Ehrmantraut MD DEGREE MD ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>						22c. DATE SIGNED 7/17/68					
22d. PHYSICIAN'S NAME (Type) Wilfred R. Ehrmantraut						22e. ADDRESS 1125 Rockville Pike, Rockville, Md					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 7/20/68		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven		23d. LOCATION (City or Town) (County) (State) Rockville Mont. Md/					
24. FUNERAL DIRECTOR Robert A. Pumphrey 7557 Wisc. Ave. Beth. Md.						25a. REC'D BY REGISTRAR JUL 22 1968 DATE		25b. REGISTRAR'S SIGNATURE J. Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV 1/68

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print) Baby			First Boy Middle MARSH Last			2a. DATE OF DEATH Month 24 Day 68 Year		2b. HOUR 703P M		
3 SEX Male		4 RACE Caucasian		5 DATE OF BIRTH July 24, 1968		6 AGE (n years last birthday) YRS.		IF UNDER 24 HRS MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) Montgomery Co. Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Montgomery Md.				
10. CITY OR TOWN OF DEATH Bethesda			11 NAME OF HOSPITAL OR INSTITUTION (if not in hosp. tal give street address) Naval Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) N/A		12b. KIND OF BUSINESS OR INDUSTRY N/A		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Virginia			13b. COUNTY McLean		13c. CITY OR TOWN McLean		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 1530 Buena Vista	
14. FATHER'S NAME First Stanley Middle M. Last Marsh			15 MOTHER'S MAIDEN NAME First Marjorie Middle J. Last Myers							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown N/A (if yes give war or dates of service)			16b. SOCIAL SECURITY NO N/A		17 INFORMANT McLean Address Va. Stanley M. Marsh, 1530 Buena Vista Ave.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 114X Congestive Heart Failure DUE TO, OR AS A CONSEQUENCE OF Cyathostomus foetalis (severe) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. In utero (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 3 hr.										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 1100										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME FARM STREET FACTORY) OFFICE BUILDING, ETC		21f. LOCATION Street or R.F.D. No		City or Town		County State		
22a. I certify that (I) (this hospital) attended the deceased from July 24, 1968 , to July 24, 1968 , that (I) (we) last saw the deceased alive on July 24, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (and) (do not) view the body after death.										
22b. SIGNATURE P. Swartz, MD					DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED July 26, 1968			
22d. PHYSICIAN'S NAME (Type) P. SWARTZ, M. D.					22e. ADDRESS Naval Hospital, Bethesda, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Transfer		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY Medical School		23d. LOCATION (City or Town) (County) (State) NNMC, Bethesda, Md.				
24. FUNERAL DIRECTOR ADDRESS					25a. REC'D BY REGISTRAR DATE JUL 29 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, pages 1 and 2 director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 Item #63, Film #103 8/5/68 km									
1 DECEASED-NAME (Type or print) First Middle Last Norman Lee Martin						2a. DATE OF DEATH Month Day Year July 9 1968		2b. HOUR 9:00 M	
3 SEX Male		4. RACE White		5. DATE OF BIRTH 14 September 1967		6 AGE (In years last birthday) YRS 10 9		IF UNDER 1 YEAR MONTHS DAYS 10 9	
7a. BIRTHPLACE (State or foreign country) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.			
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) The Clinical Center, NIH		12a. USUA. OCCUPAT ON (Kind of work done during most of working life, even if retired) Child		12b. KIND OF BUSINESS OR INDUSTRY None			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Pennsylvania		13b. COUNTY New Holland		13c. CITY OR TOWN New Holland		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER Route #1	
14 FATHER'S NAME First Middle Last Floyd Martin			15. MOTHER'S MAIDEN NAME First Middle Last Mable Shirk						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No		16b. SOCIAL SECURITY NO. None		17 INFORMANT Bethesda, Md. Address The Medical Records, The Clinical Center/					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary and Gastrointestinal Hemorrhage DUE TO, OR AS A CONSEQUENCE OF Acute reticulum cell leukemia with thrombocytopenia CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 200.0 (b) with thrombocytopenia DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 1/2 Hours 2 Weeks	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Probable pseudomonas septicemia									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, not by medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 5 July 1968 to 9 July 1968 , that (I) (we) last saw the deceased alive on 9 July 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Robert E. Gallagher, M.D.				DEGREE MD		ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED 9 July 1968	
22d. PHYSICIAN'S NAME (Type) Robert E. Gallagher, MD.				22e. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE July 11, '68		23c. NAME OF CEMETERY OR CREMATORY Mennonite Cemetery		23d. LOCATION (City or Town) (County) (State) New Holland, Pa.			
24. FUNERAL DIRECTOR Robert A. Pumpphrey				ADDRESS 7857 Wisconsin Ave.		25a. REC'D BY REGISTRAR DATE JUL 15 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed with in 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

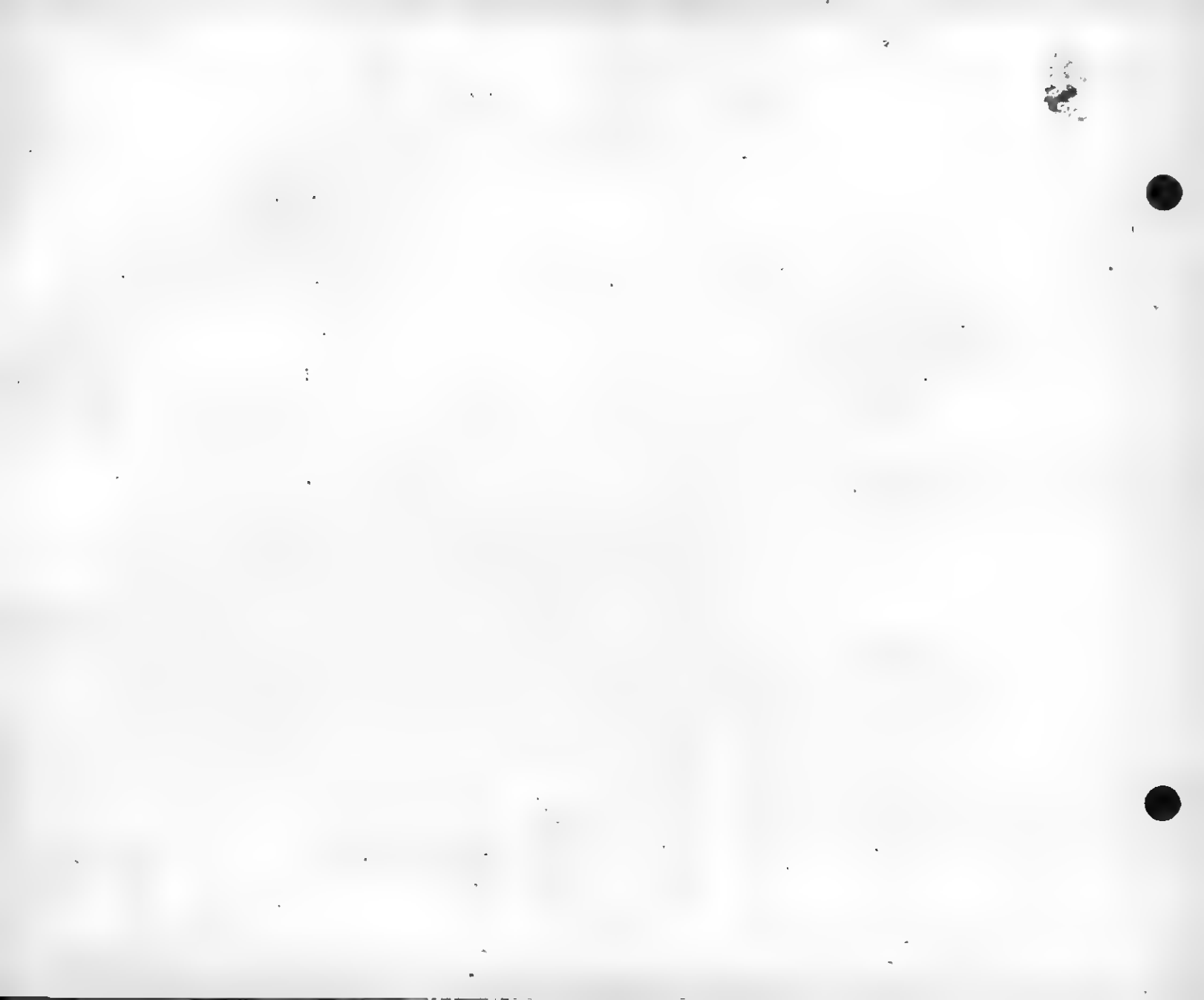
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

YR A15ME (5)
10M REV 1-68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or Print)		First	Middle	Last	2a DATE KNOWN OF DEATH	Month	Day	Year	2b HOUR
Richard Edwin Martin					<input checked="" type="checkbox"/> ESTI <input type="checkbox"/> MATED	7	14	1968	12:05 AM
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN	2c DATE PRONOUNCED DEAD		Month	Day
Male	White	Aug. 24, 1906	61 YRS			Month 7 Day 14 Year 1968		12:05	
7a BIRTHPLACE (State or foreign country)	7b CITIZEN OF WHAT COUNTRY?	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Fremont, Ohio	U.S.A..			Montgomery		Md.			
10 CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b KIND OF BUSINESS OR INDUSTRY				
Silver Spring	Holy Cross		Supervisor		Telephone Co.				
13a USUAL RESIDENCE (Where deceased lived or institution on residence before admission) STATE	13b. COUNTY	13c CITY OR TOWN	3d INSIDE CITY LIMITS?	13e STREET AND NUMBER					
Md.	Montgomery	Sil. Spring	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	224 Northwest Terrace					
14 FATHER'S NAME	First	Middle	Last	15 MOTHER'S MAIDEN NAME	First	Middle	Last		
Edward John Martin,				Ethel Balsizer					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16b SOCIAL SECURITY NO	17. INFORMANT		ADDRESS					
NO	577-01-1190	Seona E. Martin, Wife		224 Northwest Terr. Silver Spring, Md.					
18 CAUSE OF DEATH (Enter on only one cause per line for (a) (b) and (c))									
PART 1. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) <i>Acute Coronary Insufficiency</i>									
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Coronary Artery Heart Disease</i>									
DUE TO, OR AS A CONSEQUENCE OF (c)									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a EXTERNAL CAUSE WAS PR MARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No		City or Town		County State	
22a. I certify that I took charge of the remains described above, held on death resulted from: Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE		CHIEF MEDICAL EXAMINER		ASS STANT MEDICAL EXAMINER		22b DATE SIGNED			
EXAMINER'S NAME (Type)		Beldon R. Hooper, M.D.		DEPUTY MEDICAL EXAMINER		JULY 14, 1968			
23a BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)			
Burial		July 16, 1968		Parklawn Cemetery		Rockville, Maryland			
24 FUNERAL DIRECTOR		25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE					
Warner E. Humphrey, Inc.		JUL 18 1968		Charles Judge					

434 Georgia Ave.
Silver Spring, Md.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. (The funeral director should remove carbon papers, pages 1 and 2, and in any event, within 72 hours after death, should be filed with the State Dept. of Health prior to burial, cremation, or removal.)

VR A 5-7
30A REV 1-58

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print) First <u>ALBERT</u> Middle <u>L.</u> Last <u>MASERICK</u>			2a. DATE OF DEATH Month <u>7</u> Day <u>20</u> Year <u>68</u>			2b. HOUR <u>11:30</u> M				
3 SEX <u>MALE</u>		4 RACE <u>WHITE</u>		5 DATE OF BIRTH <u>11/13/02</u>		6 AGE (In years lost birthday) <u>65</u> YRS		IF UNDER 1 YEAR MONTHS <u> </u> DAYS <u> </u> HOURS <u> </u> MIN <u> </u>		
7a. BIRTHPLACE (State or foreign country) <u>WASH. DC</u>		7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <u>MONTGOMERY COUNTY</u> Md.				
10. CITY OR TOWN OF DEATH <u>SILVER SPRING</u>			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>HOLY CROSS</u>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <u>BANKING</u>			12b. KIND OF BUSINESS OR INDUSTRY	
13a. U.S.A. RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <u>MD.</u>			13b. COUNTY <u>MONTG.</u>		13c. CITY OR TOWN <u>Sil. Spring</u>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <u>210 INDIAN SPR. DR.</u>	
14. FATHER'S NAME First <u>PAUL</u> Middle <u>MASARYK</u> Last <u> </u>			15. MOTHER'S M A DEN NAME First <u>KAROLINA</u> Middle <u>BARANET</u> Last <u> </u>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <u>NO</u> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. <u>578-40-9696</u>		17. INFORMANT Address <u>MRS. FRANCES MASERICK</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cerebral hemorrhage</u> 4 1.4 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO, OR AS A CONSEQUENCE OF (c) <u> </u>									APPROXIMATE INTERVAL: FROM ONSET AND DEATH <u>12 hours</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. <u> </u> Month <u> </u> Day <u> </u> Year <u> </u> P.M. <u> </u>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED White <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (1) (this hospital) attended the deceased from <u>July 20, 19 68</u> , to <u>July 20, 19 68</u> , that (1) (we) last saw the deceased alive on <u>July 20, 19 68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>Nelson G. Goodman, M.D.</u> DEGREE <u> </u> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>						22c. DATE SIGNED				
22d. PHYSICIAN'S NAME (Type) <u>Nelson G. Goodman, M.D.</u>			22e. ADDRESS <u>6854 New Hampshire Ave. T.P., Md.</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE <u>7/24/68</u>		23c. NAME OF CEMETERY OR CREMATORY <u>GATE OF HEAVEN</u>		23d. LOCATION (City or Town) (County) (State) <u>WHEATON</u> <u> </u> <u>MD.</u>			
24. FUNERAL DIRECTOR <u>Hendon Funeral Home</u>			ADDRESS <u>4748 Wisc. Ave Wash DC</u>		25a. REC'D BY REGISTRAR <u> </u> DATE <u>JUL 26 1968</u>		25b. REGISTRAR'S SIGNATURE <u>J Charles Judge</u>			



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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
10268 - CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) <i>Elizabeth</i>			First <i>Elizabeth</i> Middle <i>Methis</i> Last <i>Methis</i>			2a. DATE OF DEATH 7 Month 7 Day 19 68		2b. HOUR 6A M	
3. SEX <i>Female</i>		4. RACE <i>Caus.</i>		5. DATE OF BIRTH <i>7-4-1893</i>		6. AGE (In years last birthday) <i>75</i> YRS		F UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <i>Greensburg Penna</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery County</i> Md.			
10. CITY OR TOWN OF DEATH <i>Wheaton, Md.</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>AMU. Nursing Home</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>HOUSEWIFE</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>AT HOME</i>			
13a. USUAL RESIDENCE (Where deceased lived, if institution - Residence before admission) STATE <i>md.</i>		13b. COUNTY <i>Montgomery</i>		13c. CITY OR TOWN <i>Silver Spring</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>917 S. Belgrade Rd.</i>	
14. FATHER'S NAME First <i>HAIR</i> Middle <i>CARREL</i> Last <i>COITEN</i>			15. MOTHER'S MAIDEN NAME First <i>Rose</i> Middle <i>?</i> Last <i>?</i>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>no</i> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO <i>194-28-2097</i>		17. INFORMANT <i>North Rose</i>		Address <i>Same As 13</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Artery Disease</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Congestive heart Failure</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Diabetes mellitus</i>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Diabetes mellitus</i>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 68		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <i>Approx -</i> , 19 <i>66</i> , to <i>7-7</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>7-3</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) <i>not</i> view the body after death.									
22b. SIGNATURE <i>Gilbert B. Cushner, M.D.</i>				22c. DATE SIGNED <i>7-8-68</i>					
22d. PHYSICIAN'S NAME (Type) <i>Gilbert B. Cushner, M. D.</i>				22e. ADDRESS <i>11161 N. H. Ave., Silver Spring, Md.</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <i>7-8-1968</i>		23c. NAME OF CEMETERY OR CREMATORY <i>FT. LINCOLN Crematory</i>		23d. LOCATION (City or Town) (County) (State) <i>Committee Manor MD</i>			
24. FUNERAL DIRECTOR <i>Goldberg Funeral Home</i>		ADDRESS <i>4217-94 H.W.</i>		25a. REC'D BY REGISTRAR <i>10</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		JUL 11 1968	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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CERTIFICATE OF DEATH

10269

10270

1. DECEASED NAME (Type or print) <i>Helen M. Mayer</i>			2a. DATE OF DEATH Month <i>July</i> Day <i>5</i> Year <i>68</i>			2b. HOUR <i>6:59</i> AM	
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>2/19/1894</i>		6. AGE (in years last birthday) <i>74</i> YRS.	
7a. BIRTHPLACE (State or foreign country) <i>W. Va.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i> Md.	
10. CITY OR TOWN OF DEATH <i>Bethesda</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban Hospital</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>None</i>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <i>Maryland</i>		13b. COUNTY <i>Montgomery</i>		13c. CITY OR TOWN <i>Rockville</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER <i>1120 Maple Ave.</i>		14. FATHER'S NAME First Middle Last <i>Joseph Winesdorffer</i>		15. MOTHER'S MAIDEN NAME First Middle Last <i>Hobbs</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO <i>252-20-1250</i>		17. INFORMANT <i>Kenneth Mayer - son - 5924 Lee Hwy</i>		Address <i>Arlington, Va.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Renal shut down</i>							<i>2-3 days</i>
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Coronary thrombosis</i>							<i>1 1/2 yrs</i>
DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>1110 Diabetic Mellitus</i>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <i>Apr.</i> , 19 <i>67</i> , to <i>July</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>4 July</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Paul T. Noone MD</i>				22c. DATE SIGNED <i>5 Jul 68</i>		22d. PHYSICIAN'S NAME (Type) <i>Paul T. Noone</i>	
22e. ADDRESS <i>5201 Randolph Rd Potomac Md</i>		22f. ADDRESS <i>5201 Randolph Rd Potomac Md</i>		22g. ADDRESS <i>5201 Randolph Rd Potomac Md</i>		22h. ADDRESS <i>5201 Randolph Rd Potomac Md</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <i>7/8/68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Arlington National</i>		23d. LOCATION (City or Town) (County) (State) <i>Arlington, Va.</i>	
24. FUNERAL DIRECTOR <i>Tye n' cooler</i>		24a. REC'D BY REGISTRAR <i>9</i>		24b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		24c. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

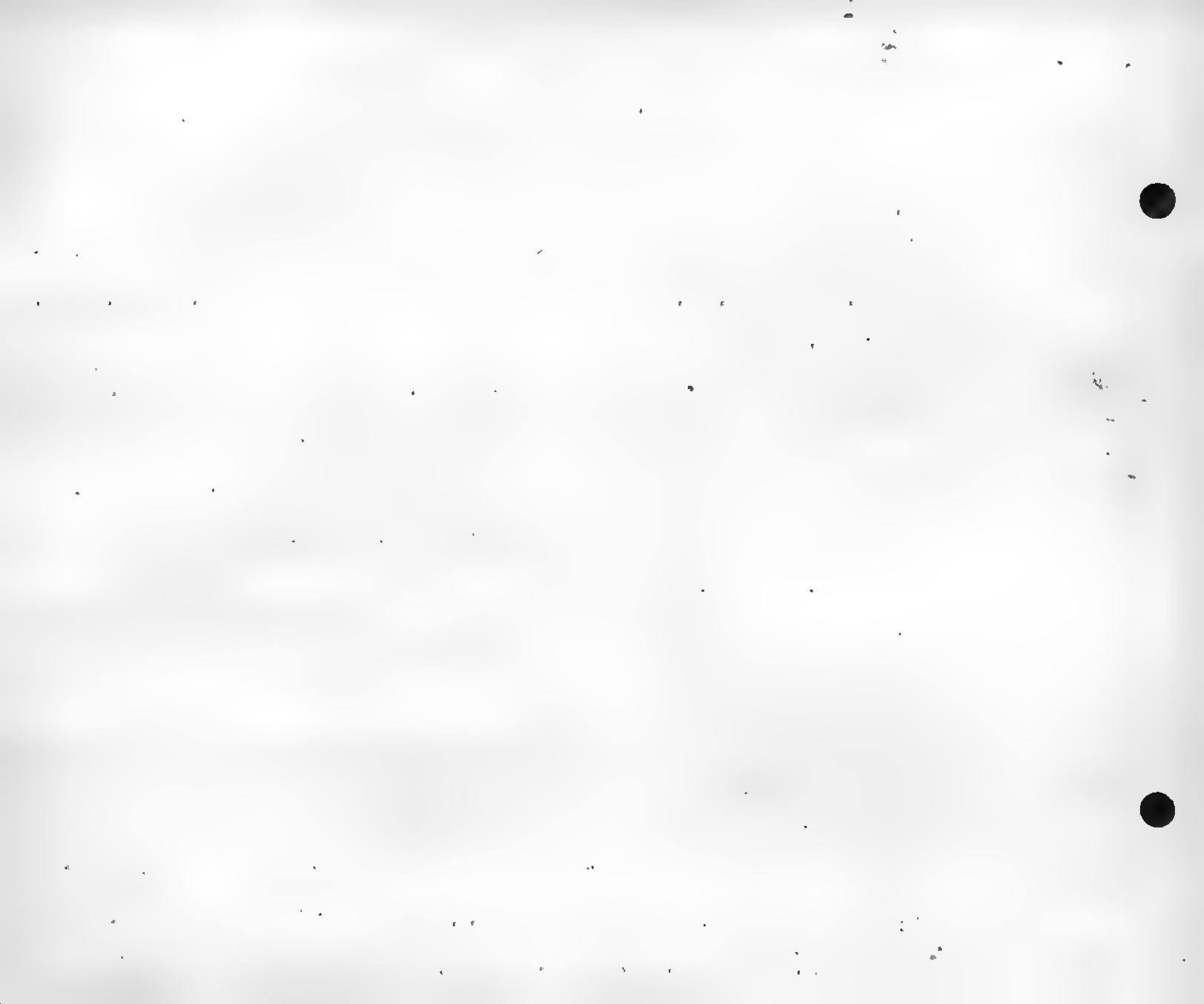


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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print) <i>Charles E. Torney</i>			First	Middle	Last	2a. DATE OF DEATH Month <i>July</i> Day <i>24</i> Year <i>1968</i>			2b. HOUR <i>2 p.m.</i>		
3 SEX <i>Male</i>		4 RACE <i>White</i>		5 DATE OF BIRTH <i>8-15-91</i>		6 AGE (In years last birthday) <i>76</i> YRS.		IF UNDER 1 YEAR MONTHS		IF UNDER 24 HRS HOURS	
7a. BIRTHPLACE (State or foreign country) <i>Washington, DC</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <i>Montgomery Co</i>					
10. CITY OR TOWN OF DEATH <i>Washington</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>St. Elizabeth's Hospital</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Retired</i>			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) - STATE <i>D.C.</i>			13b. COUNTY <i>D.C.</i>			13c. CITY OR TOWN <i>Washington</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>1250 - 21st St.</i>	
14. FATHER'S NAME <i>Charles E. Torney</i>			First	Middle	Last	15. MOTHER'S MAIDEN NAME <i>Mary E. Taylor</i>			First	Middle	Last
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			(If yes give war or dates of service)			16b. SOCIAL SECURITY NO. <i>578-07-1026</i>		17 INFORMANT <i>Charles E. Torney</i>		Address <i>413</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Diffuse bilateral bronchopneumonia</i> <i>12/1/9</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Cerebro-vascular accident (R+)</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Generalized arterio-sclerosis</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 week</i> <i>4 mos</i> <i>5 yrs</i>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Emphysema</i>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <i>3-9-68</i> , 19 <i>68</i> , to <i>7-20</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>7-19</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Herbert S. Gates</i>			22c. PHYSICIAN'S NAME (Type) <i>HERBERT S. GATES</i>			22d. ADDRESS <i>819 - EAST CAPITOL ST. 20003</i>		22e. DATE SIGNED <i>7-20-68</i>		22f. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMAT., REMOVAL (Specify)			23b. DATE <i>July 23-68</i>			23c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill Cemetery</i>			23d. LOCATION (City or Town) (County) (State) <i>Washington, D.C.</i>		
24. FUNERAL DIRECTOR <i>Samuel Bros.</i>			ADDRESS <i>Gd. Hope Rd. SE DC</i>			25a. REC'D BY REGISTRAR <i>JUL 24 1968</i>			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 1-183. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1 DECEASED NAME (Type or Print) ^{First} <u>Maude</u> ^{Middle} <u>Elizabeth</u> ^{Last} <u>McElfish</u>					2a DATE KNOWN OF DEATH <input type="checkbox"/> Month <input checked="" type="checkbox"/> Day <u>11</u> Year <u>1968</u>		2b HOUR <u>1:30</u> M <u>P</u>		
3 SEX <u>Fe</u>	4 RACE <u>W.</u>	5 DATE OF BIRTH <u>7/9/1893</u>	6 AGE (In years last birthday) <u>75</u> YRS	7 UNDER 1 YEAR MONTHS <u>0</u> DAYS <u>0</u>	8 IF UNDER 24 HRS MONTHS <u>0</u> DAYS <u>0</u>	2c DATE PRONOUNCED DEAD Month <u>July</u> Day <u>11</u> Year <u>1968</u>		2d HOUR <u>2:00</u> P.M.	
7a BIRTHPLACE (State or foreign country) <u>Penna.</u>		7b CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <u>Montgomery</u> Md.			
10 CITY OR TOWN OF DEATH <u>Gaithersburg</u>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>105 Floral Drive</u>			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <u>housewife</u>		12b KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE <u>Maryland</u>			13b COUNTY <u>Montgomery</u>		13c CITY OR TOWN <u>Gaithersburg</u>	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET AND NUMBER <u>105 Floral Drive</u>		
14. FATHER'S NAME ^{First} <u>Davis</u> ^{Middle} <u>C.</u> ^{Last} <u>Miller</u>			15. MOTHER'S MAIDEN NAME ^{First} <u>Catherine</u> ^{Middle} <u></u> ^{Last} <u>Robinette</u>						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknown)		16b SOCIAL SECURITY NO <u>216-18-1632</u>		17 INFORMANT <u>Joseph B. McElfish</u>		ADDRESS <u>Cumberland</u>			
18 CAUSE OF DEATH (Enter only one cause per line for (a) (b) and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Insufficiency Acute</u> <u>4127</u> (Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.) (b) <u>Cardiovascular Disease</u> (c) <u></u> DUE TO, OR AS A CONSEQUENCE OF								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>Years</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>4200</u>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. <u>19</u> P.M. <u></u>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No		City or Town	County	State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <u>John B. Bell</u> M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED <u>July 11, 1968</u>			
EXAMINER'S NAME (Type)			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
			ADDRESS (Street, city, town, or county)						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <u>7-14-68</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Centerville</u>		23d. LOCATION (City or Town) <u>Centerville</u> (County) <u>Pa</u> (State) <u>Pa</u>			
24. FUNERAL DIRECTOR <u>Ernest C. Gartner</u>			ADDRESS <u>Gaithersburg, Md</u>			25a. REC'D BY REG. STRAR <u>JUL 15 1968</u>		25b. REG. STRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH**

1. DECEASED-NAME (Type or print) FRANCIS E McGilvery			2a. DATE OF DEATH Month July Day 6 Year 1968			2b. HOUR 7 1/2 M	
3 SEX male		4. RACE white		5. DATE OF BIRTH July 8, 1912		6 AGE (in years last birthday) 50 YRS.	
7a. BIRTHPLACE (State or foreign country) Wash. DC		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.	
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Wash. Suburban		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) President		12b. KIND OF BUSINESS OR INDUSTRY Management Assoc Corp	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Bethesda		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 6512 Elgin Lane		14 FATHER'S NAME First Bernard J. McGilvery Middle E Last McGilvery		15 MOTHER'S MAIDEN NAME First Josephine O'meara Middle J Last O'meara			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown yes (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 598-07-6696		17 INFORMANT Josephine H. McGilvery, Wife		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Extensive Thrombosis DUE TO, OR AS A CONSEQUENCE OF (b) illness, peritonitis DUE TO, OR AS A CONSEQUENCE OF (c) acute diverticulitis caecum							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 hr 3 days 6 days
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Right colonic caecum resection 6/30/68							
19a. DATE OF OPERATION June 30/68		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED acute diverticulitis caecum		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month 19 Day 19 Year 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE John C. Robben DEGREE MD ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>						22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (Type) John C. Robben MD		22e. ADDRESS 10406 Conant Ave Washington Md					
23a. BURIAL, CREMATION, or other disposition Burial		23b. DATE 7-9-1968		23c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery		23d. LOCATION (City or Town) (County) (State) Rockville, Montgomery Co., Md	
24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc., 5130 Wisc. Ave. N.W., Wash., D.C., 20016				25a. REC'D BY REGISTRAR JUL 10 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	

CERTIFICATE OF DEATH

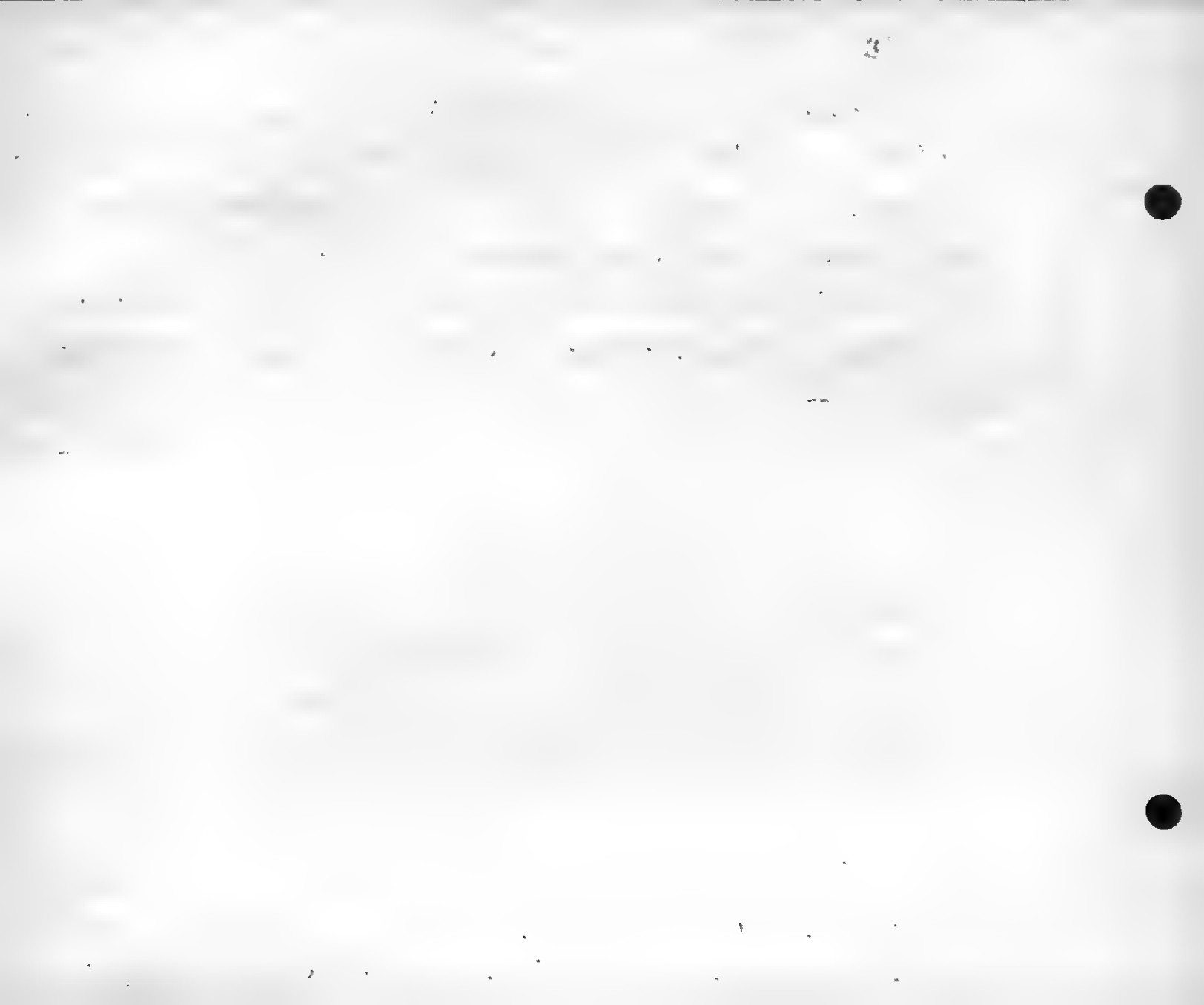
10873

1083

1 DECEASED NAME (Type or print) Dennis Michael McKee "A"			2a DATE OF DEATH Month July Day 2 Year 1968			2b HOUR 8:45 P.M.	
3 SEX MALE		4 RACE WHITE		5 DATE OF BIRTH July 2, 1968		6 AGE (In years last birthday) YRS.	
7a BIRTHPLACE (State or foreign country) MARYLAND		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH MONTGOMERY COUNTY, Md	
10 CITY OR TOWN OF DEATH SILVER SPRING		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) HOLY CROSS HOSPITAL		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) none		12b KIND OF BUSINESS OR INDUSTRY --	
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland		13b COUNTY Pt. George		13c CITY OR TOWN Adelphi		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e STREET AND NUMBER 7921 15th Avenue		14 FATHER'S NAME First Dennis Middle Michael Last McKee		15 MOTHER'S MAIDEN NAME First Jan Middle Louise Last Helmick			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) no		16b SOCIAL SECURITY NO. none		17 INFORMANT Jan Helmick McKee		Address 7921 15th Ave. Adelphi, Md.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 777X Prematurely DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 hrs 50 min.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 176							
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f LOCATION Street or R.F.D. No. City or Town County State			
22a I certify that (I) (this hospital) attended the deceased from 7/2 , 1968, to 7/2 , 1968, that (I) (we) last saw the deceased alive on 7/2 , 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b SIGNATURE George R. Spence M.D. DEGREE George R. Spence M.D.				22c DATE SIGNED 7/2/68			
22d PHYSICIAN'S NAME (Type) George R. Spence M.D.				22e ADDRESS 1515 Highland Drive Silver Spring, Maryland			
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE July 6, 1968		23c NAME OF CEMETERY OR CREMATORY Beverly Heights Cemetery		23d LOCATION (City or Town) (County) (State) Morgantown, West Virginia	
24 FUNERAL DIRECTOR Warner E. Humphrey, Inc. Silver Spring, Md.				25a REC'D BY REGISTRAR JUL 10 1968		25b REGISTRAR'S SIGNATURE J. Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1 DECEASED-NAME (Type or print)			First	Middle	Last	2a DATE OF DEATH		2b HOUR			
Richard Wayne McKee "B"						July 2, 1968		3:30 P.M.			
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER 1 YEAR			
Male		White		July 2, 1968		YRS. — MONTHS — DAYS —		IF UNDER 24 HRS. — MIN. —			
7a BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH					
Maryland		USA				Montgomery County Md.					
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b KIND OF BUSINESS OR INDUSTRY			
Silver Spring			Holy Cross Hospital			none					
13a. US. AL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER		
Maryland			P. George		Adelphi		YES		7921 15th Avenue		
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last
Dennis Michael McKee						Jan Louise Helmick					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)			16b SOCIAL SECURITY NO			17 INFORMANT			Address		
						Jan Helmick McKee			7921 15th Ave. Adelphi, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pneumonia</u>											
777x DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.											
(b) DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION											
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED											
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)											
21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19											
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>											
21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)											
21f. LOCATION Street or R.F.D. No. City or Town County State											
22a. I certify that (I) (this hospital) attended the deceased from <u>7/2/68</u> , 19 <u>68</u> , to <u>7/2/68</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>7/2/68</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>George R. Spence M.D.</u> DEGREE ATTENDING PHYS. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>											
22c. DATE SIGNED <u>7/2/68</u>											
22d. PHYSICIAN'S NAME (Type) <u>GEORGE R. SPENCE M.D.</u>											
22e. ADDRESS <u>1515 HIGHWAY DRIVE SILVER SPRING</u>											
23a. BURIAL, CREMATION, REMOVAL (Specify)											
23b. DATE <u>July 6, 1968</u>											
23c. NAME OF CEMETERY OR CREMATORY <u>Reverly Heights Cemetery</u>											
23d. LOCATION (City or Town) (County) (State) <u>Morgantown, West Virginia</u>											
24. FUNERAL DIRECTOR <u>Arner E. Pumphrey, Inc. Silver Spring, Md.</u> ADDRESS <u>8434 Seatons Ave</u>											
25a. REC'D BY REGISTRAR <u>JUL 10 1968</u>											
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>											



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
10M REV 1/68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1 DECEASED NAME (Type or Print)			First Middle Last			2a DATE KNOWN OF DEATH			2b HOUR		
Bernard			Alton McKnew-			ESTIMATED DATE MATED <input checked="" type="checkbox"/> July 31 1968			2 P M		
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	7 IF UNDER 1 YEAR MONTHS	8 IF UNDER 24 HRS HOURS	9 MIN	2c DATE PRONOUNCED DEAD			2d HOUR	
M.	W.	Dec. 21-1912	55 YRS				July 31 1968			2 P M	
7a BIRTHPLACE (State or foreign country)			7b CITIZEN OF WHAT COUNTRY?			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH		
Washington D.C.			USA						Montgomery Md.		
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of work life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY		
Rockville -			11945 Goya Dr.			Superintendent			Furniture		
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b COUNTY			13c CITY OR TOWN			13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
Md.			Montgomery			Rockville			11945 Goya Drive		
14 FATHER'S NAME First Middle Last			15 MOTHER'S MAIDEN NAME First Middle Last								
Ira Thomas McKnew			Margaret Strother								
16a WAS DECEASED EVER U.S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SECURITY NO			17 INFORMANT			ADDRESS		
NO			578-03-0965			Mrs. Audrey M. McKnew, Potomac, Md.			11945 Goya Dr.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia - Carbon Monoxide Poisoning. 1 hr.											
DUE TO, OR AS A CONSEQUENCE OF (b)											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION											
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?											
20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH			21b TIME OF INJURY Month, Day, Year			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b)					
			12 P M 7/31 1968			Attached here to exhaust file of death in closed					
2d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e PLACE OF INJURY (At home, farm, street, factory, office building, etc)			21f LOCATION Street or RFD No.			City or Town		
			Home garage -			11945 Goya Drive Rockville			Montgomery Md.		
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE			CHIEF MEDICAL EXAMINER			7936 Old Georgetown Rd.			22b. DATE SIGNED		
EXAMINER'S NAME (Type)			JOHN G. BELL, M.D.			ASSISTANT MEDICAL EXAMINER			1 Aug 1968		
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			ADDRESS (Street, city, town, or county) Bethesda, Maryland		
23a BURIAL, CREMATION, REMOVAL (Specify)			23b DATE			23c NAME OF CEMETERY OR CREMATORY			23d LOCATION (City or Town) (County) (State)		
Burial			8/5/68			Parklawn Cemetery			Rockville, Montg. Md.		
24 FUNERAL DIRECTOR			7557 Wisconsin Ave			25a REC'D BY REGISTRAR			25b REGISTRAR'S SIGNATURE		
ROBERT A. PUMPHREY, Bethesda, Maryland						DATE AUG 5 1968			Charles Judge		

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours of death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) First Middle Last Jeanne K. McMAHON			2a. DATE OF DEATH Month Day Year July 28 1968			2b. HOUR 30 M			
3. SEX Female		4. RACE White		5. DATE OF BIRTH May 26 - 1920		6. AGE (in years last birthday) 48 YRS.		7. UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Washington DC		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.			
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Suburban		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) House wife		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Kensington		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 3205 Calverdale	
14. FATHER'S NAME First Middle Last Wilbur F. Kellogg			15. MOTHER'S MAIDEN NAME First Middle Last Katherine Noel						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, (no, or unknown)		16b. SOCIAL SECURITY NO —		17. INFORMANT John McMahon, Husband, above					
18. CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARCINOMA OF THE OVARY 1850 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 yrs
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 1150									
19a. DATE OF OPERATION 1150		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from Dec 1966, to 7/28, 1968, that (I) (we) lost saw the deceased alive on 7/28 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Richard H. Pollen MD		22c. DATE SIGNED 7/28/68		22d. PHYSICIAN'S NAME (Type) RICHARD H. POLLEN		22e. ADDRESS 10400 CONNECTICUT AVE KENSINGTON			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 7-31-1968		23c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery		23d. LOCATION (City or Town) (County) (State) Washington, D.C.			
24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc., N.W., Wash., D.C., 20016				25a. REC'D BY REGISTRAR DATE JUL 31 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			

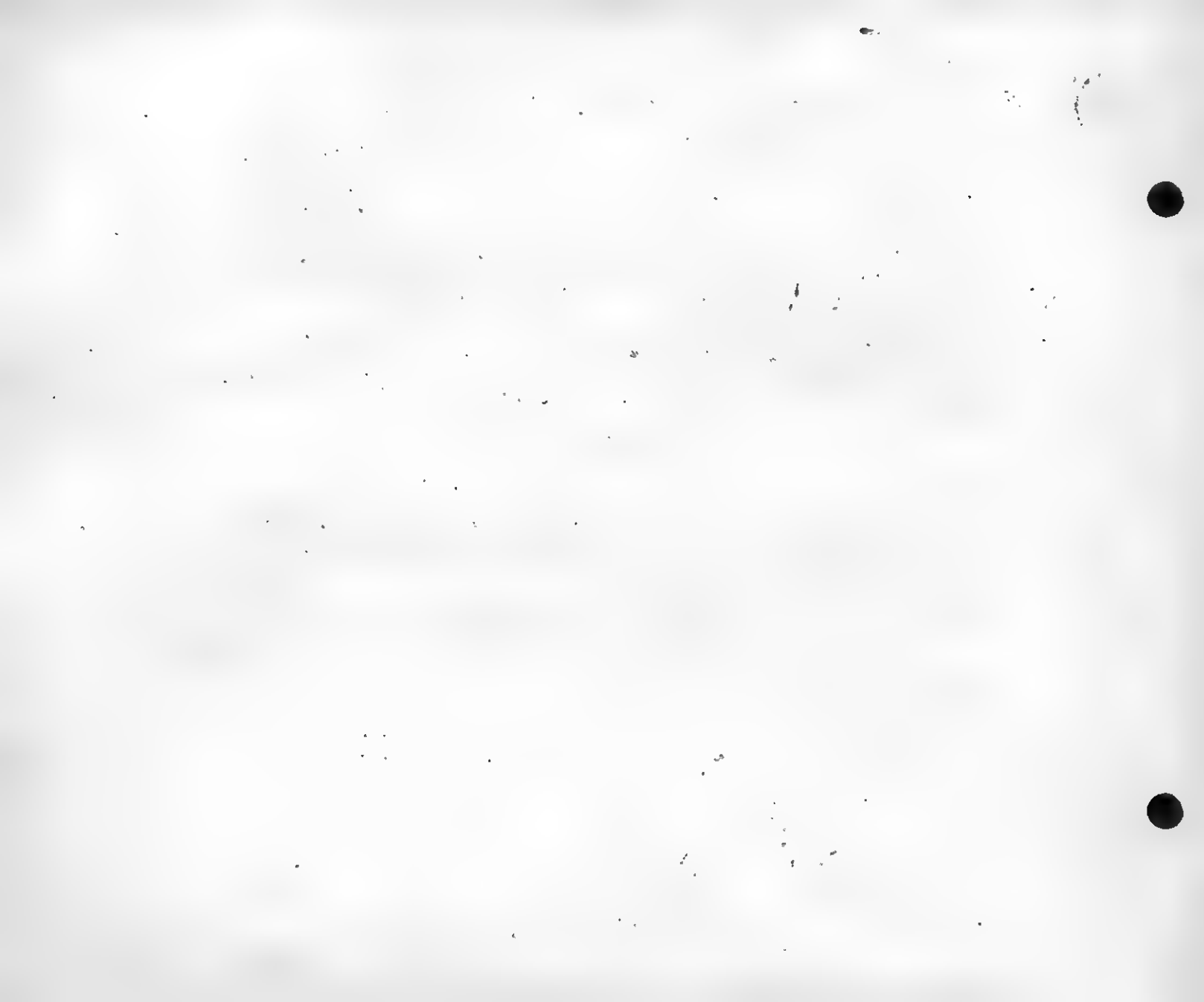
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) Albert First James M. McMurtry Middle James M. McMurtry Last			2a. DATE OF DEATH Month July Day 22 Year 1968			2b. HOUR 5:00 P.M.	
3 SEX Male		4 RACE White		5. DATE OF BIRTH Jan. 26, 1906		6 AGE (In years last birthday) 62 YRS	
7a BIRTH-PLACE (State or foreign) Boston, Mass.		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md	
10 CITY OR TOWN OF DEATH Olney		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Brooke Grove Foundation		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Handy man		12b KIND OF BUSINESS OR INDUSTRY Funeral	
13a U.S.A. RESIDENCE (Where deceased lived, if institut on, Residence before admission) STATE Maryland		13b COUNTY Montgomery		13c CITY OR TOWN Barnesville		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e STREET AND NUMBER		14 FATHER'S NAME First Albert J. Middle McMurtry Last		15. MOTHER'S MAIDEN NAME First Elizabeth D. Middle Lynch Last			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No (If yes give war or dates of service)		16b SOCIAL SECURITY NO. 230-05-5243		17 INFORMANT Mrs. Paul Catter Address 3804 Waldbine Cherry Chase, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))							
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cancer							
DUE TO, OR AS A CONSEQUENCE OF (b) Carcinomatosis							
DUE TO, OR AS A CONSEQUENCE OF (c) Adenocarcinoma of rectum							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 124							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 7/19 , 19 68 , to 7/22 , 19 68 , that (I) (we) last saw the deceased alive on 7/21 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE C. H. Ligon		DEGREE M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 7/22/68	
22d. PHYSICIAN'S NAME (Type) C. H. Ligon		22e. ADDRESS Sandy Spring, Md 20860					
23a. BURIAL, CREMATION, REMOVAL (Specify) Buried		23b. DATE 7/24/68		23c. NAME OF CEMETERY OR CREMATORY St. Marys Cath.		23d. LOCATION (City or Town) (County) (State) Barnesville Montg. Md.	
24. FUNERAL DIRECTOR William B. Hilton, Barnesville, Md.		ADDRESS		25a. REC'D BY REGISTRAR JUL 25 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	



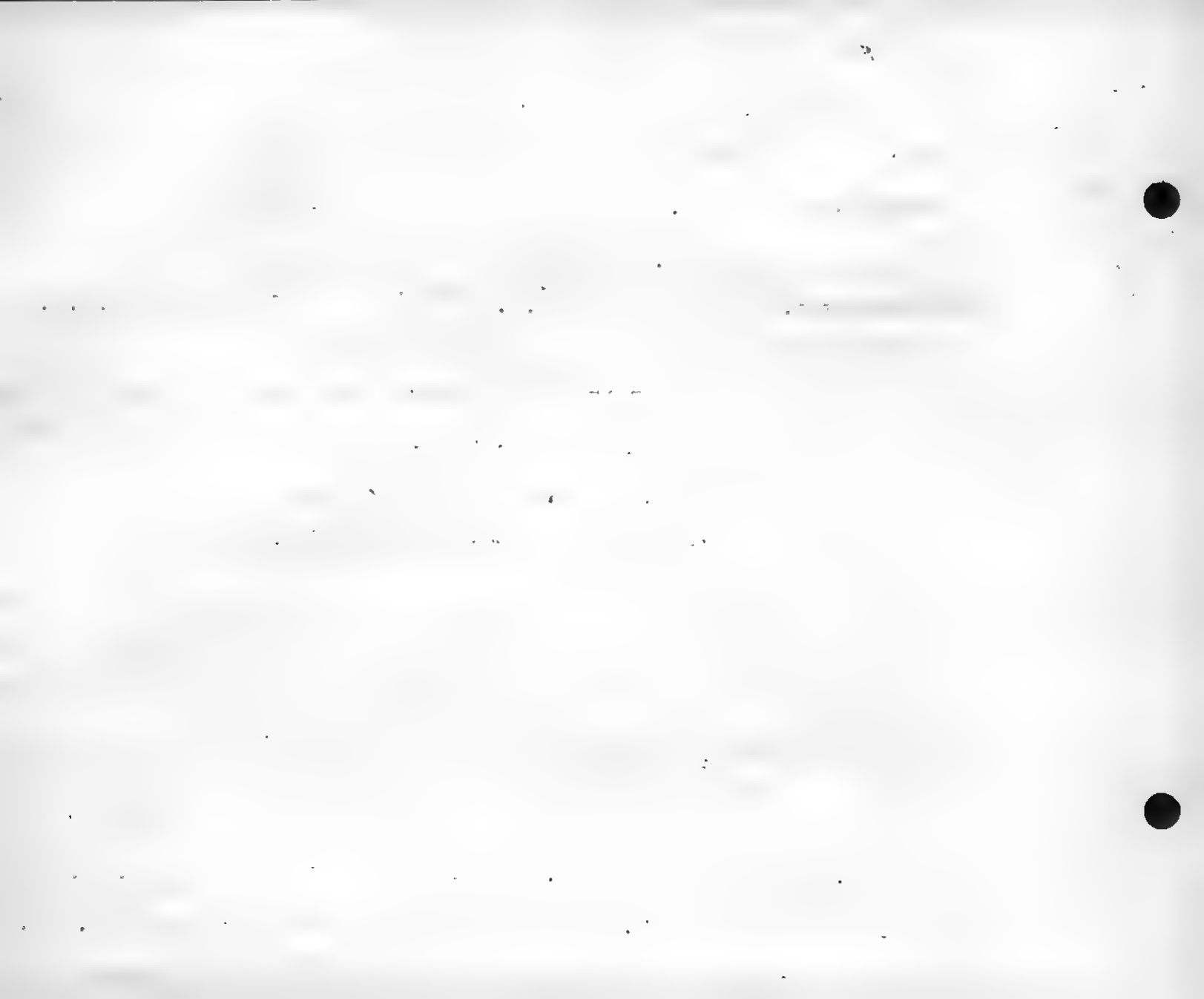
10278

CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR	
ALBERTA				McNAMARA	7 11 68		5 A M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH 12/13/1886		6. AGE (In years lost birthday) 81 YRS		IF UNDER 1 YEAR MONTHS DAYS
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.		
Pennsylvania		U. S. A.		901 Arcola Ave Univ. Nursing Home		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Saleslady		12b. KIND OF BUSINESS OR INDUSTRY
10. CITY OR TOWN OF DEATH Wheaton		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12c. CITY OR TOWN Washington D.C.		13. RESIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 1518 Upshur St. N.W.
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN Washington D.C.		13d. RESIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 1518 Upshur St. N.W.
14. FATHER'S NAME William Feltman		First	Middle	Last	15. MOTHER'S MAIDEN NAME Robina Beattie		First	Middle Last
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown		16b. SOCIAL SECURITY NO 578-09-6348		17. INFORMANT Nursing Home Records (same as above)		Address		
no								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Pulmonary Embolism - 1 day</u> <u>4129</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Thrombo Phlebitis, Rt. Leg - 6 weeks</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arterio-Sclerotic Heart Disease - 5 years</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>420</u>								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <u>5/21</u> , 19 <u>68</u> , to <u>7/11</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>7-10</u> 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) view the body after death.								
22b. SIGNATURE <u>Francis X. Richardson</u> M.D.				22c. DATE SIGNED <u>7/11/68</u>		22d. PHYSICIAN'S NAME (Type) Francis X. Richardson, M.D.		
22e. ADDRESS 11412 Veirs Mill Road, Wheaton, Md. 20902								
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 7/15/68		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		23d. LOCATION (City or Town) (County) (State) Prince Georges Co. Md.		
24. FUNERAL DIRECTOR <u>The S.H. Hines Co.</u>		ADDRESS <u>2901-14th St. N.W. D.C.</u>		25a. RECD BY REGISTRAR <u>JUL 15 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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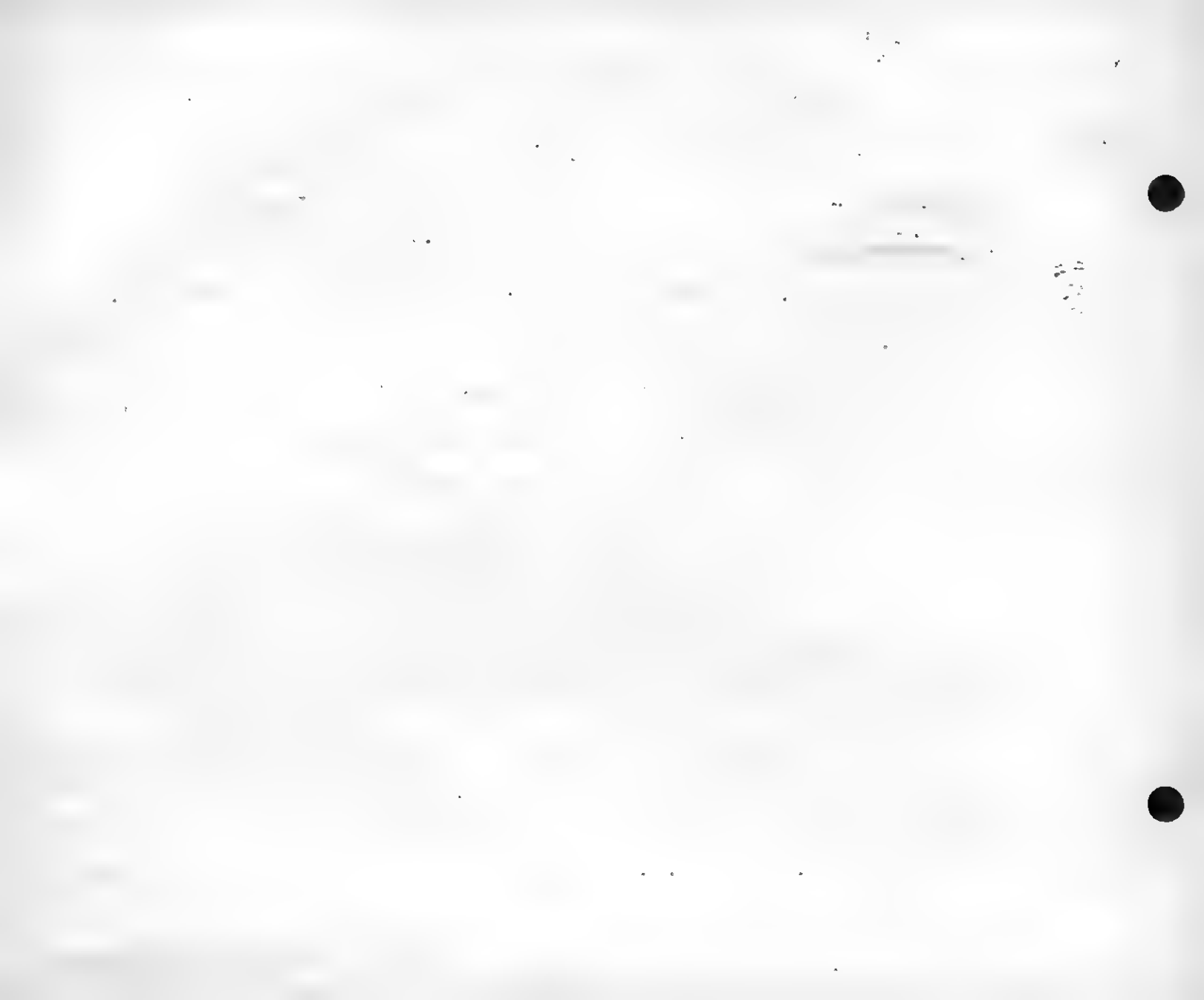


FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1 DECEASED NAME (Type or Print)		First		Middle		Last		2a DATE KNOWN OF DEATH	
Norman		(NMN)		McNeill		2a DATE KNOWN OF DEATH		Month Day Year	
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (in years last birthday)		2c DATE PRONOUNCED DEAD	
Male		White		5/21/1893		75 yrs		Month Day Year	
7a BIRTHPLACE (State or foreign)		7b CIT ZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9 COUNTY OF DEATH		10	
North Carolina		USA		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Montgomery		A M	
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUA. OCCUPATION (Kind of work done during most of working life even if retired)		12b KIND OF BUSINESS OR INDUSTRY		13	
Bethesda, Maryland		4509 Gretna St.							
13a US RESIDENCE (Where deceased lived, if institution)		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS?		13e STREET AND NUMBER	
4509 Gretna St.		Montgomery		Bethesda		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		4509 Gretna St.	
14 FATHER'S NAME		First		Middle		Last		15 MOTHER'S MAIDEN NAME	
Dr. James		McNeill		Anne		Pimberton			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b SOCIAL SECURITY NO		17 INFORMANT		ADDRESS		18	
YES		RETIRED 1959		223-40-9207		Carobel Glover McNeill, wife			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))		PART 1 DEATH WAS CAUSED BY.		IMMEDIATE CAUSE (a)		4129		10	
				Acute Coronary Insufficiency				Sudden	
				(b) Cardio-vascular disease				Years	
				(c)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED?		20 AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b TIME OF INJURY Month, Day Year		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
		HOUR A.M. P.M. 19							
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No		City or Town		County State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE		John G. Ball		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b DATE SIGNED	
EXAMINER'S NAME (Type)		John G. Ball, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		July 17 1968	
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
						ADDRESS (Street, city, town, or county)			
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town)		(County) (State)	
Burial		24 JULY 1968		ARLINGTON NATIONAL		ARLINGTON VA.			
24 FUNERAL DIRECTOR		ADDRESS		25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE			
RINALDI FUNERAL HOME		7400 GEORGETOWN AVE, NW DC		JUL 23 1968		Charles Judge			



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10280

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers: pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a COUNTY MONTGOMERY b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Germantown c LENGTH OF STAY IN 1b Germantown		2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before adm ssion) a STATE Maryland b COUNTY Montgomery c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Germantown	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Route #118		d. STREET ADDRESS Route 118 e IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) Andrew First Miller Middle Miller Last Miller		4. DATE OF DEATH July 30 1968 Month July Day 30 Year 1968	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 11/16/1902
9 AGE (In years last birthday) 65 yrs		10 IF UNDER 1 YEAR Months 30 Days 30 Hours 30 Min.	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b KIND OF BUSINESS OR INDUSTRY Restaurant	
11. BIRTHPLACE (County & State, or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Johann Miller		14. MOTHER'S MAIDEN NAME Barbara Orchsler	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO 577-12-7407	
17 INFORMANT Frances P. Miller-same item # 2		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: 1621 IMMEDIATE CAUSE (a) Pulmonary Congestion DUE TO (b) Bronelogenic Carcinoma DUE TO (c) Hypertensive Cardiovascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH 1 week 7 months	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIB'G <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Port II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 9 April 1968 , to 30 July 1968 , that (I) (we) lost soul the deceased alive on 7/23 1968 , and that death occurred at 10A.M. from causes and on the date stated above.			
22a. SIGNATURE John Fawcett		22b. DATE SIGNED 7/30/68	
22c. PHYSICIAN'S NAME (Type) John Fawcett		22d. ADDRESS Dawsonville, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8/2/68	
23c. NAME OF CEMETERY OR CREMATORY Parklawn		23d. LOCATION (City or Town) (County) (State) Rockville, Maryland	
24. FUNERAL DIRECTOR Tyson Wheeler Funeral Home 1331 Rock. Pike		25a. REC'D BY REGISTRAR AUG 1 1968	
ADDRESS Rockville, Maryland		25b. REGISTRAR'S SIGNATURE Charles Judge	

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of the death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PMS-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

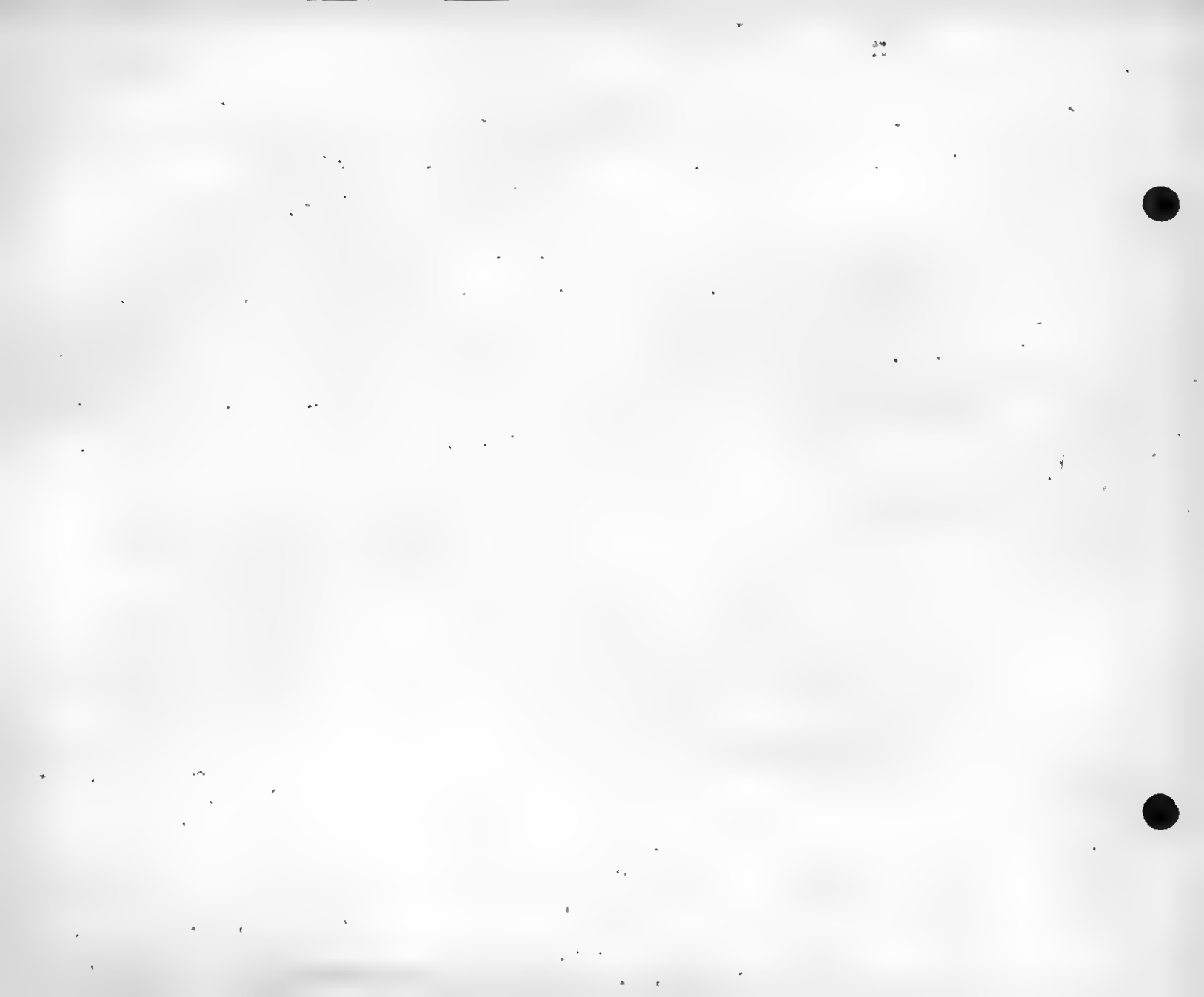
1. DECEASED-NAME (Type or Print) Arthur		First Montfield		M date Miller		2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> Month 7 Day 6 Year 1968		2b. HOUR 4:45 M PM	
3 SEX M.	4 RACE W.	5 DATE OF BIRTH July 1, 1921	6 AGE (In years last birthday) 47 YRS	IF UNDER 1 YEAR MONTHS 0 DAYS 0		IF UNDER 24 HRS HOURS 0 MIN. 0		2c. DATE PRONOUNCED DEAD Month July Day 6 Year 1968	
7a. BIRTH-PLACE (State or foreign country) New York		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Montgomery			
10. CITY OR TOWN OF DEATH Silver Spring		11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) 916 Copley Lane				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Retired Mechanical Engineer		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 916 Copley Lane	
14 FATHER'S NAME First Arthur Middle H. Last Miller		15 MOTHER'S MAIDEN NAME First Marie Middle Glass Last Glass							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16b. SOCIAL SECURITY NO 169-18-8070		17. INFORMANT D. Jean Miller ADDRESS 916 Copley Lane Silver Spring, Maryland					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Evulsion of Brain + Skull								Sudden	
DUE TO, OR AS A CONSEQUENCE OF (b) Gun shot blast of Head self inflicted.									
DUE TO, OR AS A CONSEQUENCE OF (c) Gun shot blast of Head self inflicted.									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 776X									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day Year 7-6 1968		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18.) Put muzzle of Rifle in mouth + Pulled Trigger					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Home		21f. LOCATION Street or R.F.D. No 916 Copley Lane		City or Town Silver Spring		County Montgomery	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from. Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE John E. Ball		EXAMINER'S NAME (Type) John E. Ball		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
				ADDRESS (Street, city, town, or county) Silver Spring, Md.		22b. DATE SIGNED July 7, 1968			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE July 10, 1968		23c. NAME OF CEMETERY OR CREMATORY Rocklawn Cemetery		23d. LOCATION (City or Town) Rockville, Maryland		(County) (State)	
24. FUNERAL DIRECTOR'S NAME (Type) Charles E. Humphrey, Inc.		24b. ADDRESS Silver Spring, Md.		25a. REC'D BY REGISTRAR Charles Judge		25b. REGISTRAR'S SIGNATURE Charles Judge		DATE JUL 12 1968	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) <i>CLARENCE Wilbur MILLER</i>		First Middle Last		2a. DATE OF DEATH Month <i>7</i> Day <i>24</i> Year <i>68</i>		2b. HOUR <i>6:50</i> A.M.	
3. SEX <i>Male</i>		4. RACE <i>Cauc</i>		5. DATE OF BIRTH <i>12-28-1899</i>		6. AGE (In years lost birthday) <i>68</i> YRS	
7a. BIRTHPLACE (State or foreign country) <i>Pa.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>MONTGOMERY</i> Md.	
10. CITY OR TOWN OF DEATH <i>Bethesda</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Business</i>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md.</i>		13b. COUNTY <i>Montgomery</i>		13c. CITY OR TOWN <i>Rockville</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER <i>904 Baltimore Rd.</i>		14. FATHER'S NAME First Middle Last <i>George Washington Miller</i>		15. MOTHER'S MAIDEN NAME First Middle Last <i>Lydia Woodring</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) <i>yes</i>		16b. SOCIAL SECURITY NO. <i>1212-24-4153</i>		17. INFORMANT <i>Marie - Wife - Same</i>		Address	
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial infarction</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <i>Coronary atherosclerosis</i> DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>30 min</i> <i>5 yrs.</i>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <i>1963</i> to <i>7-24</i> , 1968, that (I) (we) last saw the deceased alive on <i>7-16</i> , 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Donald L Bucy MD</i>		22c. PHYSICIAN'S NAME (Type) <i>DONALD L BUCY</i>		22d. ADDRESS <i>809 VEIRS Mill Rd Rockville</i>		22e. DATE SIGNED <i>7-24-68</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>7/27/68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Parklawn</i>		23d. LOCATION (City or Town) (County) (State) <i>Rockville, Md.</i>	
24. FUNERAL DIRECTOR <i>Tyson Wheeler Funeral Home-1331 Rockville Pike</i> <i>Rockville, Md.</i>				25a. REC'D BY REGISTRAR <i>JUL 30 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PH-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR ATSM 10M REV 1-68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
1. DECEASED NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH		2b. HOUR		
HAZEL			Lee			MILLER		7-21 1968		
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	7 UNDER 1 YEAR	8 UNDER 24 HRS	2c. DATE PRONOUNCED DEAD		2d. HOUR		
FE	CAUC	Jan. 28, 1911	57 YRS	MONTHS	DAYS	7-21		68		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.		
TENN.		U.S.A.				Montgomery				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired)		12b. KIND OF BUSINESS OR INDUSTRY		
SILVER SPRING			3640 Glen Eagles Dr.			Housewife		own home		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		
Md.			Montgomery			SIL SPR.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			13e. STREET AND NUMBER				
Bruce Baker			Laura Masterson			3640 Glen Eagles Dr.				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT		ADDRESS		
No			577-05-5352			Mr. Benjamin H. Baker		Rockville, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))			19. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?				
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4129						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			(b) DUE TO, OR AS A CONSEQUENCE OF			Approximate interval between onset and death				
			(c) DUE TO, OR AS A CONSEQUENCE OF							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?				
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
			P.M. 19							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. no City or Town County State				
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
22b. DATE SIGNED			22c. NAME OF CEMETERY OR CREMATORY			22d. LOCATION (City or Town) (County) (State)				
July 21, 1968			St. Lincoln Cemetery			Prince Georges Co.				
23a. BURLINGHAM REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)	
Burial			July 25, 1968			St. Lincoln Cemetery			Prince Georges Co.	
23e. FUNERAL DIRECTOR			23f. ADDRESS			23g. REC'D BY REGISTRAR			23h. REGISTRAR'S SIGNATURE	
C. Glen Carter			4344 Georgia Ave.			JUL 29 1968			Charles Judge	
Warner E. Pumphrey, Inc.			Silver Spring, Md.							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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10284

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

1968

CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) First <u>LUCY</u> Middle <u>DAY</u> Last <u>MILLER</u>			2a. DATE OF DEATH Month <u>7</u> Day <u>24</u> Year <u>68</u>		2b HOUR <u>4:30</u> M
3. SEX <u>Fe</u>	4 RACE <u>Wht.</u>	5 DATE OF BIRTH <u>4-7-89</u>		6 AGE (In years last birthday) <u>79</u> YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN
7a. BIRTHPLACE (State or foreign country) <u>W. Va.</u>	7b. CITIZEN OF WHAT COUNTRY? <u>Amer.</u>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <u>Montgomery County</u> Md.	
10 CITY OR TOWN OF DEATH <u>TAKOMA PARK, MD.</u>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>WASH. SAN. & HOSPITAL</u>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <u>Retired: School teacher</u>	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <u>W. Va.</u>		13b. COUNTY <u>Berkeley</u>	13c. CITY OR TOWN <u>Martinsburg</u>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER <u>Rt. 4, Box 329</u>
14. FATHER'S NAME First <u>FRANCIS</u> Middle <u>MILLER</u> Last <u>MILLER</u>			15. MOTHER'S MAIDEN NAME First <u>MARY</u> Middle <u>Sutton</u> Last <u>Sutton</u>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown) <u>no</u> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <u>236-40-7915</u>		17. INFORMANT <u>FACE Sheet - Chart</u> Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> <u>4107</u> DUE TO, OR AS A CONSEQUENCE OF Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebrovascular heart disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 hours</u> <u>1 day</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>4-</u>					
19a. DATE OF OPERATION <u>7-15-68</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Insertion of permanent pacemaker</u>		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <u>19</u>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)	
21d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC		21f. LOCATION Street or R.F.D. No City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>July 5</u> , 19 <u>68</u> , to <u>July 25</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>July 25</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Phyllis A. Gordon</u>		DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>7/24/68</u>	
22d. PHYSICIAN'S NAME (Type) <u>Phyllis A. Gordon</u>		22e. ADDRESS <u>2309 Shorefield Rd. W. Va.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <u>July 28, 1968</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mountain View</u>	
23d. LOCATION (City or Town) <u>Sharpsburg</u>		23e. COUNTY <u>Wash. Md.</u>		23f. STATE <u>Md.</u>	
24. FUNERAL DIRECTOR <u>Howard R. Brown - Martinsburg, W. Va.</u>		25a. REC'D BY REGISTRAR DATE <u>JUL 26 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print) Shirley T. Miller			2a. DATE OF DEATH Month July Day 9 Year 1968		2b. HOUR 7³⁰ M
3 SEX F	4 RACE W	5 DATE OF BIRTH 6-1-25		6. AGE (In years lost birthday) 43 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN
7a. BIRTHPLACE (State or foreign country) Pennsylvania	7b. CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md	
10 CITY OR TOWN OF DEATH Bethesda	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Suburban		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Personnel officer		12b. KIND OF BUSINESS OR INDUSTRY Engineering
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.	13b. COUNTY Montgomery	13c. CITY OR TOWN Derwood	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 19400 Muncester Rd	
14 FATHER'S NAME First ? Middle Teplitz Last Teplitz		15 MOTHER'S MAIDEN NAME First Betty Middle Solomon Last Solomon			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO (If yes give grade and dates of service)		16b. SOCIAL SECURITY NO.		17 INFORMANT Leopold Miller husband Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage 431.0 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Essential Hypertension DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 32 hours 10 years					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 331X None					
19a. DATE OF OPERATION —		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED —		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from 1964 to July 9, 1968 , that (I) (we) lost the deceased alive on July 9, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Stephen C. Cromwell MD				22c. DATE SIGNED 7-9-68	
22d. PHYSICIAN'S NAME (Type) Stephen C. Cromwell, MD				22e. ADDRESS Rockville, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION		23b. DATE 7/10/68		23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CREMATORY SUTTLAND, PR. GEO. MD.	
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY		7557 Wisconsin Ave. Bethesda, Maryland		25a. REC'D BY REGISTRAR JUL 15 1968	
				25b. REGISTRAR'S SIGNATURE Charles Judge	



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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print) Frederick Bryan Mills			2a DATE OF DEATH Month 7 Day 1 Year 1968			2b HOUR 9:30 P M			
3 SEX Male		4 RACE WHITE		5 DATE OF BIRTH 3/1/98		6 AGE (In years last birthday) 70 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN	
7a BIRTHPLACE (State or foreign country) Virginia		7b CITIZEN OF WHAT COUNTRY? U.S.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Montgomery Md.			
10 CITY OR TOWN OF DEATH Silver Spring		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Holy Cross Hos.		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Sec. Fr. NOL.		12b KIND OF BUSINESS OR INDUSTRY N.O.L.			
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.		13b COUNTY Montg.		13c CITY OR TOWN Silver Spring		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 513 Blick Drive	
14 FATHER'S NAME First Middle Last Joseph G. Mills			15 MOTHER'S MAIDEN NAME First Middle Last Mary Lillian Embrey						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) Yes (If yes give war or dates of service) WW I		16b SOCIAL SECURITY NO. 578-24-4579		17 INFORMANT Caroline E. Mills Address 513 Blick Drive Silver Spring, Md.					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) 16 years APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 weeks									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 Emphysema and Bronchitis									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f LOCATION Street or R.F.D. No. City or Town County State					
22a I certify that (I) (this hospital) attended the deceased from 2/10/66 , to 7/1/68 , that (I) (we) last saw the deceased alive on 7/1/68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE John F. Curry MD		22c DATE SIGNED 7/2/68		22d PHYSICIAN'S NAME (Type) John F. Curry					
22e ADDRESS 9801 Georgia Ave									
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE July 5, 1968		23c NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery		23d LOCATION (City or Town) (County) (State) Washington, D. C.			
24a FUNERAL DIRECTOR Warner E. Humphrey, Inc.		24b ADDRESS 8434 Georgia Ave. Silver Spring, Md.		25a REC'D BY REGISTRAR JUL - 8 1968		25b REGISTRAR'S SIGNATURE Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return one carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) KATIE		First EDNA Last M. Istead		2a. DATE OF DEATH 7 Month 21 Day 68 Year		2b. HOUR 6 A.M.	
3. SEX F		4. RACE W		5. DATE OF BIRTH MARCH 30 1883		6. AGE (In years lost birthday) 85 YRS.	
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH MONTGOMERY Md	
10. CITY OR TOWN OF DEATH WASHINGTON GROVE MD		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) housewife		12a. USUAL OCCUPATION (Kind of work done during most of work ng life, even if retired) housewife		12b. KIND OF BUSINESS OR INDUSTRY DOMESTIC	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN WASHINGTON GROVE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 101 Center Street		14. FATHER'S NAME First FREDERICK Middle GROVES Last GROVES		15. MOTHER'S MAIDEN NAME First MARY Middle V. Last GILROY			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) NO		16b. SOCIAL SECURITY NO 240-48-5252		17. INFORMANT Rev. M. Istead		Address 101 Center Street Washington Grove	
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) acute cardiac failure DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) septicemia DUE TO, OR AS A CONSEQUENCE OF (c) pyelonephritis							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH seconds 1 day 2 days
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) NONE							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING ETC.		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 7/18 , 19 68 , to 7/21 , 19 68 , that (I) (we) lost saw the deceased alive on 7/20 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (I) (we) (did not) view the body after death.							
22b. SIGNATURE Melvin J. Kordon MD				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 7/22/68	
22d. PHYSICIAN'S NAME (Type) Melvin J. Kordon MD				22e. ADDRESS 13 Deer Park Drive, Garthorsburg			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 7-24-68		23c. NAME OF CEMETERY OR CREMATORY CHICAMUXEN METHODIST CHICAMUXEN		23d. LOCATION (City or Town) (County) (State) Charles MD	
24. FUNERAL DIRECTOR LUNT FUNERAL Home - WA KORE, MD				25a. REC'D BY REGISTRAR JUL 25 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	

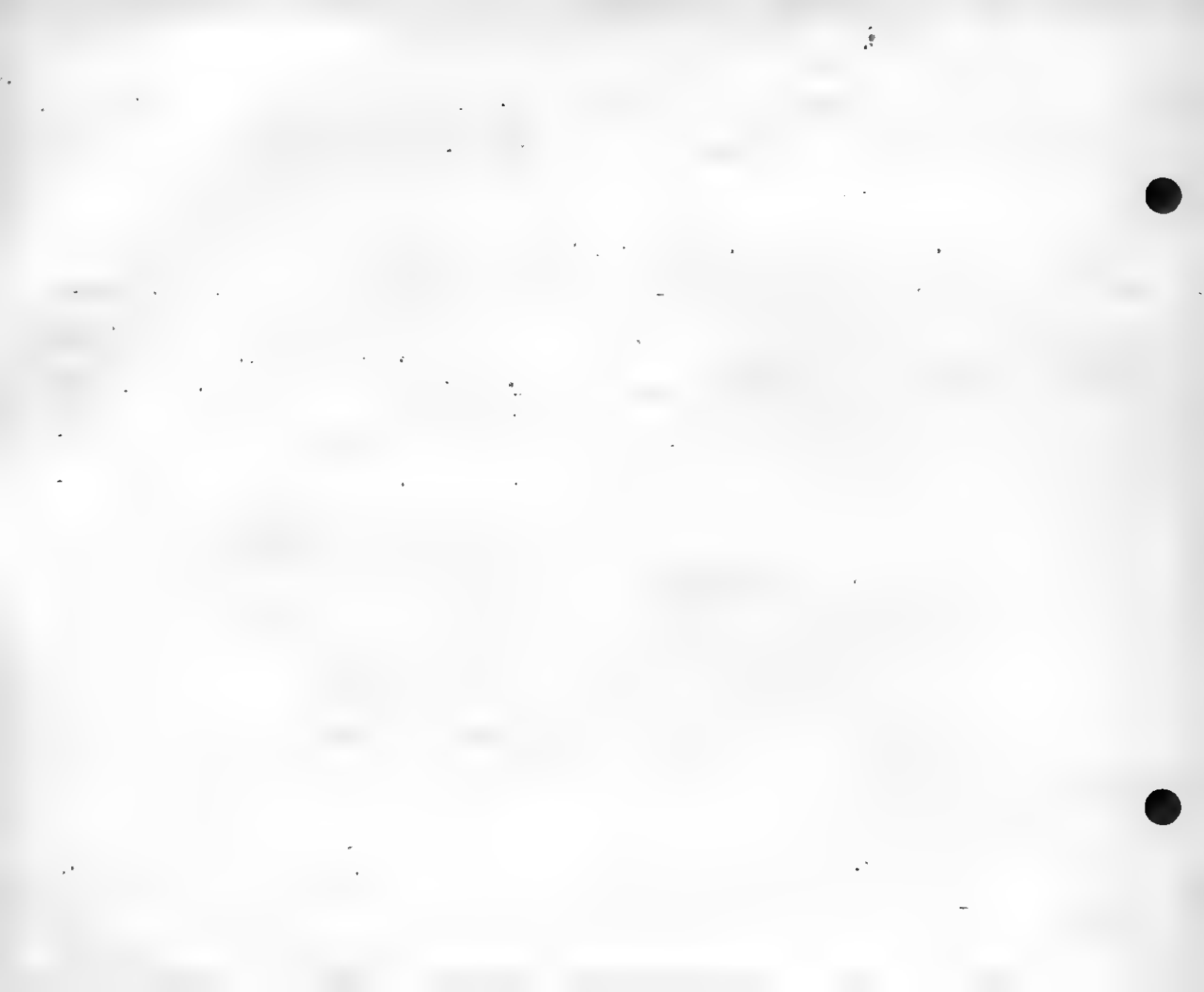


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) First Middle Last Mary Hazel Mobley			2a. DATE OF DEATH Month Day Year July 12 1968			2b. HOUR 6:30 PM	
3. SEX Female		4. RACE Negro		5. DATE OF BIRTH December 14, 1926		6. AGE (in years last birthday) 41 YRS.	
7a. BIRTHPLACE (State or foreign country) North Carolina		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.	
1d. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) The Clinical Center, NIH		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Cook		12b. KIND OF BUSINESS OR INDUSTRY Domestic	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission to State) Virginia		13b. COUNTY -- ✓		13c. CITY OR TOWN Alexandria		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 242 North Payne Street							
14. FATHER'S NAME First Middle Last Net McGee			15. MOTHER'S MAIDEN NAME First Middle Last Mozelle (Unknown)				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 096-22-1416		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda, Md. 20014			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Thrombocytopenia and punctured liver and spleen DUE TO, OR AS A CONSEQUENCE OF (b) Chronic Myelogenous Leukemia DUE TO, OR AS A CONSEQUENCE OF (c) _____ Cond. on. if any, which gave rise to immediate cause (a), stating the underlying cause lost. 2051							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 Years
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH; BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Bilateral Subdural Hemorrhage							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that 24 (this hospital) attended the deceased from June 4 , 19 68 , to July 12 , 19 68 , that (1) (we) last saw the deceased alive on July 12 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>R. Peter Mogielnicki M.D.</i> DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>				22c. DATE SIGNED 14 July 1968			
22d. PHYSICIAN'S NAME (Type) R. Peter Mogielnicki, M. D.				22e. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 7/14/68		23c. NAME OF CEMETERY OR CREMATORY Coleman Cemetery		23d. LOCATION (City or Town) (County) (State) Fairfax Co Va.	
24. FUNERAL DIRECTOR <i>Arnold F. Horne</i>				25. REC'D BY REGISTRAR JUL 16 1968 DATE			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1 DECEASED-NAME (Type or print)			First	Middle	Last	2a DATE OF DEATH		2b HOUR			
William David Moore						7 Month 6 Day 68 Year		8 ³⁰ A M			
3. SEX		4 RACE		5. DATE OF BIRTH		6 AGE (In years last birthday)		7 UNDER YEAR MONTHS DAYS			
M		White		3-20-08		60 YRS.					
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH					
D.C.		America				Montgomery Takoma Park Md					
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY			
Takoma Park			Washington Sanitarian Hospital Painted					Self-employed			
13a USUAL RESIDENCE (Where deceased lived, if instit. on. Residence before admission) STATE			13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER		
D.C.					D.C.				1530 Rhode Is. Ave NE		
14 FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last
Frank					Moore	Ida					Flowers
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b SOCIAL SECURITY NO.			17 INFORMANT			Address		
No			579-10-5246			Hospital Record					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 1621									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
DUE TO, OR AS A CONSEQUENCE OF									3-4 mos		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 1621											
DUE TO, OR AS A CONSEQUENCE OF											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (b) Chronic bronchitis + emphysema, bronchopneumonia											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
		HOUR A.M. Month Day Year P.M. 19									
21d INJURY OCCURRED		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f LOCATION		Street or RFD No.		City or Town		County	State
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>											
22a. I certify that (I) (this hospital) attended the deceased from April 25, 1968, to 7/6, 1968, that (I) (we) last saw the deceased alive on 7/5, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b SIGNATURE					DEGREE		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED		
Fenne G. Bendler M.D.									7-6/68		
22d PHYSICIAN'S NAME (Type)					22e ADDRESS						
Fenne G. Bendler MD					10820 Georgia Ave. Wheaton, Md						
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town)		(County)		(State)	
Burial		7-9-1968		Cedar Hill Cemetery		Suitland, Md.					
24. FUNERAL DIRECTOR					ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Nalley Funeral Home Mt. Rainier, Md.							JUL 11 1968		Charles Judge		



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

10890

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

201

1. DECEASED NAME (Type or Print)		First	Middle	Last	2a. DATE KNOWN OF DEATH		Month	Day	Year	2b. HOUR
WAYNE		E.		MOUNTJOY	ESTIMATED		07	24	1968	645P
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (in years)	7 UNDER 24 HRS	8 MONTHS	9 DAYS	10 HOURS	11 MIN	12 DATE PRONOUNCED DEAD	13 HOUR
M	Wh.	08/06/51	16 1/2 YRS						Month 07 Day 24 Year 1968	645P
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED		NEVER MARRIED		9 COUNTY OF DEATH		
D.C.		U.S.A.		WIDOWED		DIVORCED		Montgomery		
10. CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY				
SilverSpring		HolyCrossHosp.		Student						
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER		
Md.		PrinceGep.		Landover		YES		7714 Spring Street		
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME								
Robert		Edith								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO		17. INFORMANT		ADDRESS				
no				Robert E Mountjoy		Landover, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Fractured Cervical Vertebrae</u>										
DUE TO, OR AS A CONSEQUENCE OF (b) <u>(C3-4) with Quadriplegia and</u>										
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Respiratory Arrest incurred while diving</u>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?		YES		NO		
						YES		NO		
21a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year		21c. HOW INJURY OCCURRED (Enter nature of injury Post 1 or Part 2, Item 18)						
		4-06-62 1968		Deceased fractured neck while diving in Severn River						
21d. INJURY OCCURRED WHILE AT WORK		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc)		21f. LOCATION (Street or R.F.D. No. City or Town County State)						
		Severn River		Severn River Anne Arundel City Md						
22a. I certify that I took charge of the remains described above, held an Autopsy, Inspection, Inquiry, and in my opinion death resulted from. Natural causes, Accident, Suicide, Homicide, Undetermined manner										
22b. DATE SIGNED		22c. NAME OF CEMETERY OR OBITUARY		22d. LOCATION (City or Town) (County) (State)						
July 24, 1968		Ft Lincoln Cemetery		Colmar Manor Pro Geo Md						
23a. BURIAL CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR OBITUARY		23d. LOCATION (City or Town) (County) (State)				
Burial		July 27, 1968		Ft Lincoln Cemetery		Colmar Manor Pro Geo Md				
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
F. Gasch's Sons		Hyattsville, Md.		JUL 29 1968		Charles Judge				



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with the death certificate. 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or Print) Norine - Mouradian			2a. DATE KNOWN OF DEATH <input type="checkbox"/> Month <input checked="" type="checkbox"/> Day <input type="checkbox"/> Year July 4 1968			2b. HOUR 11:30 AM
3. SEX Female	4. RACE White	5. DATE OF BIRTH 3-24-1902	6. AGE (In years last birthday) 66 YRS	7. UNDER YEAR MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>	8. IF UNDER 24 HRS HOURS <input type="checkbox"/> MIN <input type="checkbox"/>	2c. DATE PRONOUNCED DEAD Month July Day 5 Year 1968
7a. BIRTHPLACE (State or foreign country) New York		7b. CITIZEN OF WHAT COUNTRY? U S A		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery
10. CITY OR TOWN OF DEATH Bethesda			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 4812 Earlston Dr.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Homemaker	
13a. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE Md.		13b. COUNTY Montgomery		13c. CITY OR TOWN Bethesda		13d. INSIDE CITY - YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME First William Middle Mahan Last Mahon			15. MOTHER'S MAIDEN NAME First Annie Middle - Last Oday			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16b. SOCIAL SECURITY NO 577-09-3429		17. INFORMANT ADDRESS Washington, D.C. Mrs. Theodore LeBlanc-5316 -42nd. St. N.W.		
18. CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Insufficiency Acute. 7:21 DUE TO, OR AS A CONSEQUENCE OF (b) Cardio Vascular Disease DUE TO, OR AS A CONSEQUENCE OF (c) years.						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)						
19a. DATE OF OPERATION 7-8-1968			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day Year HOUR A.M. <input type="checkbox"/> P.M. <input type="checkbox"/> 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 3 or Part 2, Item 18.)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No <input type="checkbox"/> City or Town <input type="checkbox"/> County <input type="checkbox"/> State <input type="checkbox"/>		
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>						
ACTUAL SIGNATURE John G. Ball		EXAMINER'S NAME (Type) JOHN G. BALL, M.D.		22b. DATE SIGNED 5 July 68		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 7-8-1968		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		23d. LOCATION (City or Town) (County) (State) Bladensburg, Md.
24. FUNERAL DIRECTOR JOSEPH GAWLER SONS, INC. - 5130 Wisconsin Ave. N.W. Washington, D.C.				25a. REC'D BY REGISTRAR JUL - 9 1968		25b. REGISTRAR'S SIGNATURE Charles Judge

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. **TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10092

10302

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> c. LENGTH OF STAY IN 1b <u>3 years</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>108 East Franklin Ave.</u>			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Mont.</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>108 East Franklin Ave.</u>		
3. NAME OF DECEASED (Type or print) <u>Dorothy M. Myers</u>		4. DATE OF DEATH <u>July 16 1968</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 20-1910</u>	9. AGE (In years last birthday) <u>57 yrs.</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>R. Nurse</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Gov</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Wash. D.C.</u>	
13. FATHER'S NAME <u>Hugh F. McQueeney</u>			14. MOTHER'S MAIDEN NAME <u>Mary Elizabeth Acth</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u> </u>		16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT Address <u> </u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized Carcinomatosis</u> <u>174 X</u> DUE TO <u>Carcinoma of Breast</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <u> </u> (b) <u> </u> (c) <u> </u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u> </u>					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u> </u>					
20c. TIME OF INJURY Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	
20f. (City or town) <u> </u>		(County) <u> </u>		(State) <u> </u>	
21. I certify that (I) (Name of physician) attended the deceased from <u>June 12 1967</u> to <u>July 16 1968</u> that (I) (Name of physician) saw the deceased alive on <u>July 15 1968</u> and that death occurred at <u>12:45 P.</u> M, from the causes and on the date stated above.					
22a. SIGNATURE <u>James Wegan</u>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>July 16 1968</u>	
22c. PHYSICIAN'S NAME (Type) <u>James Wegan</u>		22d. ADDRESS <u>5413 Cedar Lane - Bethesda, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial July 18 1968</u>		23b. DATE THEREOF <u>July 18 1968</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's</u>	
23d. LOCATION (City, town or county) <u>Wash. DC</u>		(State) <u> </u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Walter J. 3603</u>		ADDRESS <u>14 St. Mary's</u>		25a. REC'D BY REGISTRAR <u>JUL 18 1968</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u> </u>			



CERTIFICATE OF DEATH

10292

10303

1. DECEASED NAME (Type or print) Alice M. Naffziger			2a. DATE OF DEATH Month Day Year July 31, 1968			2b. HOUR 3:45			
3 SEX Female		4 RACE White		5. DATE OF BIRTH Sept. 5, 1907		6 AGE (In years last birthday) 61 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Iowa		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.			
10. CITY OR TOWN OF DEATH Keansington		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Carroll Hall		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) housekeeper		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE D.C.		13b. COUNTY ---		13c. CITY OR TOWN Washington		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 5230 MacArthur Blvd. NW	
14. FATHER'S NAME First Middle Last Isiah Thompson			15. MOTHER'S MAIDEN NAME First Middle Last Alice F. Barnes						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO (If yes give war or dates of service) none		17. INFORMANT Address Marjory McBroom (same as 13e)					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart Block</u> 4157 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary Atherosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) <u>Generalized Arteriosclerosis</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5+ years 10+ years 20+ years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 42...									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from Jan. 27, 1968, to July 31, 1968, that (I) (we) last saw the deceased alive on July 27, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE R. Stephen Hulbert, M.D.				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED July 31, 1968			
22d. PHYSICIAN'S NAME (Type) R. Stephen Hulbert, M.D.				22e. ADDRESS 3000 Dent Pl., N.W. Wash, D.C. 2000					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Aug. 2, 1968		23c. NAME OF CEMETERY OR CREMATORY Arlington National Cem.		23d. LOCATION (City or Town) (County) (State) Arlington, Virginia			
24. FUNERAL DIRECTOR H. DeVol				ADDRESS Wash. D.C.		25a. REC'D BY REGISTRAR DATE AUG 5 1968		25b. REGISTRAR'S SIGNATURE J. Charles Judge	
DeVol Funeral Home, 2222 Wis. Ave. N.W.									

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please have carbon papers. Pages and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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-29-68 mt
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10304

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED NAME (Type or Print) Belle NMI Neary			2a DATE KNOWN OF ESTI- DEATH MATED <input type="checkbox"/> Month 7 Day 5 Year 1968			2b HOUR 12 PM		
3 SEX Fe	4 RACE Cauc.	5 DATE OF BIRTH 1-12-83	6 AGE (in years last birthday) 85 YRS	7 UNDER 1 YEAR MONTHS 0 DAYS 0	7 UNDER 24 HRS HOURS 0 MIN 0	2c DATE PRONOUNCED DEAD Month 7 Day 5 Year 1968		
7a BIRTHPLACE (State or foreign country) Arizona		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Montgomery		
10 CITY OR TOWN OF DEATH Takoma Park		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Wash. San. and Hosp.		12a U.S.A. OCCUPATION (Kind of work done during most of working life, even if retired) housewife		12b KIND OF BUSINESS OR INDUSTRY		
13a USUAL RESIDENCE (Where deceased lived, if not institution, residence before admission) STATE Md.		13b COUNTY Montg.		13c CITY OR TOWN Bethesda		3d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 9909 Belhaven Rd.
14 FATHER'S NAME First Dan Middle - Last Reynolds			15 MOTHER'S MAIDEN NAME First Juanita Middle - Last Clark					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		(If yes give war or dates of service)		16b SOCIAL SECURITY NO		17. INFORMANT ADDRESS Hosp. Record		
18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Perforated Esophagus during DUE TO, OR AS A CONSEQUENCE OF (b) Esophagoscopy associated with DUE TO, OR AS A CONSEQUENCE OF (c) Hypertensive Cardiovascular disease								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c) 3/1								
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED?			20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b TIME OF INJURY Month, Day, Year HOUR A.M. 19 P.M.		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No		City or Town		County State
22a. I certify that I took charge of the remains described above, held in death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion								
ACTUAL SIGNATURE Belden R. Reap		EXAMINER'S NAME (Type) Belden R. Reap, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b DATE SIGNED July 8, 1968		
23a BURIAL, CREMATION, REMOVAL (Specify) BURIAL/REMOVAL		23b DATE 7/6/68		23c NAME OF CEMETERY OR CREMATORY GLOBE CEMETERY		23d LOCATION (City or Town) GLOBE, ARIZONA (County) (State)		
24 FUNERAL DIRECTOR JOSEPH GAWLER'S SONS, 5130 WIS. AVE., N.W., WASH., D.C.				25a. REC'D BY REGISTRAR JUL 10 1968		25b REGISTRAR'S SIGNATURE Charles Judge		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 17-64
30M REV 1-68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print) John Frank Nebel			2a. DATE OF DEATH Month July Day 4 Year 1968			2b. HOUR 3:30 A.M.	
3 SEX Male		4 RACE White		5 DATE OF BIRTH April 4, 1889		6 AGE (In years lost birthday) 79 YRS.	
7a BIRTHPLACE (State or foreign country) Maryland		7b CITIZEN OF WHAT COUNTRY? U.S.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 JUDICIAL OF DEATH Montgomery Md.	
10 CITY OR TOWN OF DEATH Silver Springs		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Fairland Nursing Home		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Restaurant owner		12b KIND OF BUSINESS OR INDUSTRY	
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Washington		13b COUNTY D.C.		13c INS-OR CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 3920 Benton St. N.W.	
14 FATHER'S NAME First Peter J. Middle Nebel Last Lamp			15 MOTHER'S MAIDEN NAME First Clara Middle Lamp Last Lamp				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. -		17 INFORMANT Address Wash., D.C. Jon Franklin Nebel, Son, 2826 27th St. N.W.			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory depression DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Metastases & debilitation DUE TO, OR AS A CONSEQUENCE OF (c) Squamous cell carcinoma						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Months Months	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)							
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED Where <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 5/22, 1968 to 7/4, 1968 , that (I) (we) last saw the deceased alive on 6/24, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Richard P. Delaney		DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 7/4/68			
22a. PHYSICIAN'S NAME (Type) RICHARD P. DELANEY		22e. ADDRESS 4323 HOWARD ST SILVER SPRING, MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 7-6-1968		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Suitland, Prince Georges Co. Md.	
24. FUNERAL DIRECTOR JOSEPH GAWLER'S SONS, INC. 5730 WISE AVE. NW, WASH., D.C. 20016				25a. REC'D BY REGISTRAR JUL - 9 1968		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

151507 Cleared with Medical Examiner 16 hours per.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

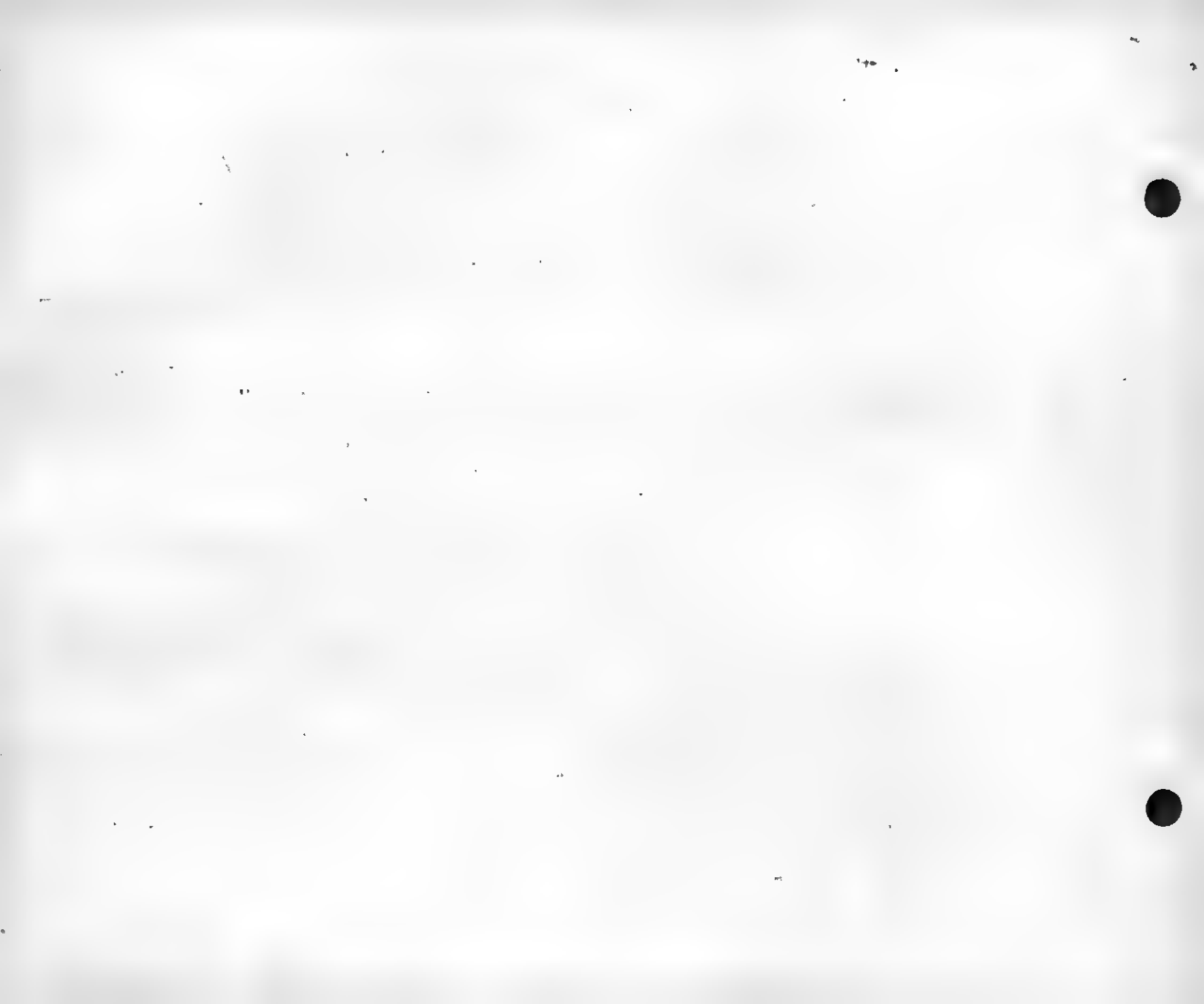
1 DECEASED NAME (Type or print) AVONZO E. NELSON			2a DATE OF DEATH Month 7 Day 26 Year 1968			2b HOUR 8:40 ^P _M	
3 SEX MALE		4 RACE WHITE		5 DATE OF BIRTH 1/8/27		6 AGE (in years last birthday) 41 yrs.	
7a BIRTHPLACE (State or foreign country) ARK.		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH MONTG.	
10 CITY OR TOWN OF DEATH SILVER SPRING		11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) HOLY CROSS Hosp.		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Retired Printer		12b KIND OF BUSINESS OR INDUSTRY Newspaper	
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md. CITY Silver Spring		13b COUNTY Montgomery		13c INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d STREET AND NUMBER 811 Lament St. N.W.	
14. FATHER'S NAME First James Middle Thomas Last Nelson			15. MOTHER'S MAIDEN NAME First Martha Middle 2. Last Caldwell				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, No or unknown No		16b SOCIAL SECURITY NO. 578-10-1253 A		17 INFORMANT Zella N. Koteler Address 11487 Lockwood Drive Silver Spring, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 151X DUE TO, OR AS A CONSEQUENCE OF (b) myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (c) 17p APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 151X							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, not by medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)			
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from July 1967 , to 7-27, 1968 , that (I) (we) last saw the deceased alive on 7-26, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.							
22b. SIGNATURE B. H. Cstrom MD				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 7-27-68	
22d. PHYSICIAN'S NAME (Type) B. H. Cstrom				22e. ADDRESS 8107 EASTERN AVE. S.S.M.D.			
23a BURLIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE July 30, 1968		23c. NAME OF CEMETERY OR CREMATORY Columbia Gardens Cemetery		23d. LOCATION (City or Town) (County) (State) Arlington, Virginia	
24 FUNERAL DIRECTOR Warner E. Humphrey, Inc.		25a. REC'D BY REGISTRAR 8434 9a. Avenue		25b. REGISTRAR'S SIGNATURE Charles Judge		DATE AUG 2 1968	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers on Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print) JOHN W. NIEPOLD						2a. DATE OF DEATH Month 7 - Day 23 - Year 1968			2b. HOUR 9:45 PM		
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH 4-1-1889		6. AGE (In years last birthday) 79 YRS		IF UNDER 1 YEAR MONTHS 19 DAYS 19		IF UNDER 24 HRS HOURS 19 MIN. 45	
7a. BIRTHPLACE (State or foreign country) FREDERICK, MD		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH MONTGOMERY Md.					
10. CITY OR TOWN OF DEATH WHEATON			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) KENSINGTON GARDENS SANT. MANUFACTURER			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland				13b. COUNTY Montgomery		13c. CITY OR TOWN Chevy Chase		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 4701 Willard Avenue 2nd Fl	
14. FATHER'S NAME First JOHN Middle W Last NIEPOLD				15. MOTHER'S MAIDEN NAME First MARY Middle EISLER Last EISLER							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO (If yes give war or dates of service)				16b. SOCIAL SECURITY NO -		17. INFORMANT ROBERT H. NIEPOLD, SON, 5111 CAMMACK DR., Address SPRINGFIELD, MD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) arteriosclerotic cerebrovascular 4379 DUE TO, OR AS A CONSEQUENCE OF (b) coronary disease DUE TO, OR AS A CONSEQUENCE OF (c) lost										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 yrs	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. 19 Month 7 Day 23 Year 1968 P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building etc.)		21f. LOCATION Street or R.F.D. No. 4/16		City or Town 7/23		County 1968		State MD	
22a. I certify that (I) (this hospital) attended the deceased from 4/16 , 19 68 , to 7/23 , 19 68 , that (I) (we) last saw the deceased alive on 7/23 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE H. F. Kreuzburg		N.D. DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 7/23/68					
22d. PHYSICIAN'S NAME (Type) H. F. Kreuzburg		22e. ADDRESS 7852 16th Ave		22f. ADDRESS 6000 D.C.							
23a. BURIAL, CREMATION, REINTERMENT REINTERMENT		23b. DATE 7-26-1968		23c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery		23d. LOCATION (City or Town) Rockville, Montgomery Co., Md.		(County)		(State)	
24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc., 5130 Wisc. Ave. N.W., Wash., D.C., 20016				ADDRESS		25a. REC'D BY REGISTRAR JUL 26 1968		25b. REGISTRAR'S SIGNATURE J. Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

10998

10808

1. DECEASED-NAME (Type or print) James R. Nurney			2a. DATE OF DEATH July 17, 1968		2b. HOUR 11 PM
3 SEX male	4. RACE Caucasian	5. DATE OF BIRTH 5-10-1904		6. AGE (In years lost birthday) 64 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Plymouth, N.C.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Montgomery Md.		
10. CITY OR TOWN OF DEATH Bethesda	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 8703 Lowell St.,	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Manufactures Repr.		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland	13b. COUNTY Montgomery	13c. CITY OR TOWN Bethesda	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 8703 Lowell St.	
14. FATHER'S NAME First Middle Last Charles Augustus		15. MOTHER'S MAIDEN NAME First Middle Last Claudia Jane Sullivan			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 241 16 1932	17. INFORMANT Address Helen Borland Nurney, Wife, see item #13		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMATOSIS 1538 DUE TO, OR AS A CONSEQUENCE OF (b) ADENOCARCINOMA OF COLON DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 WEEKS 2 YEARS
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 1538					
19a. DATE OF OPERATION 6/26/68	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED ADENOCARCINOMA OF COLON	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 6/26 , 19 68 , to 6/17 , 19 68 , that (I) (we) last saw the deceased alive on 7/12 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE William H. Dickson		DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED 7/18/68		
22d. PHYSICIAN'S NAME (Type) William H. Dickson M.D.		22e. ADDRESS 916 19TH ST N.W. WASH D.C.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 7-20-1968	23c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery	23d. LOCATION (City or Town) (County) (State) Washington, D.C.		
24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc.,		ADDRESS 5130 Wisc. Ave.	25a. REC'D BY REGISTRAR DATE JUL 22 1968	25b. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

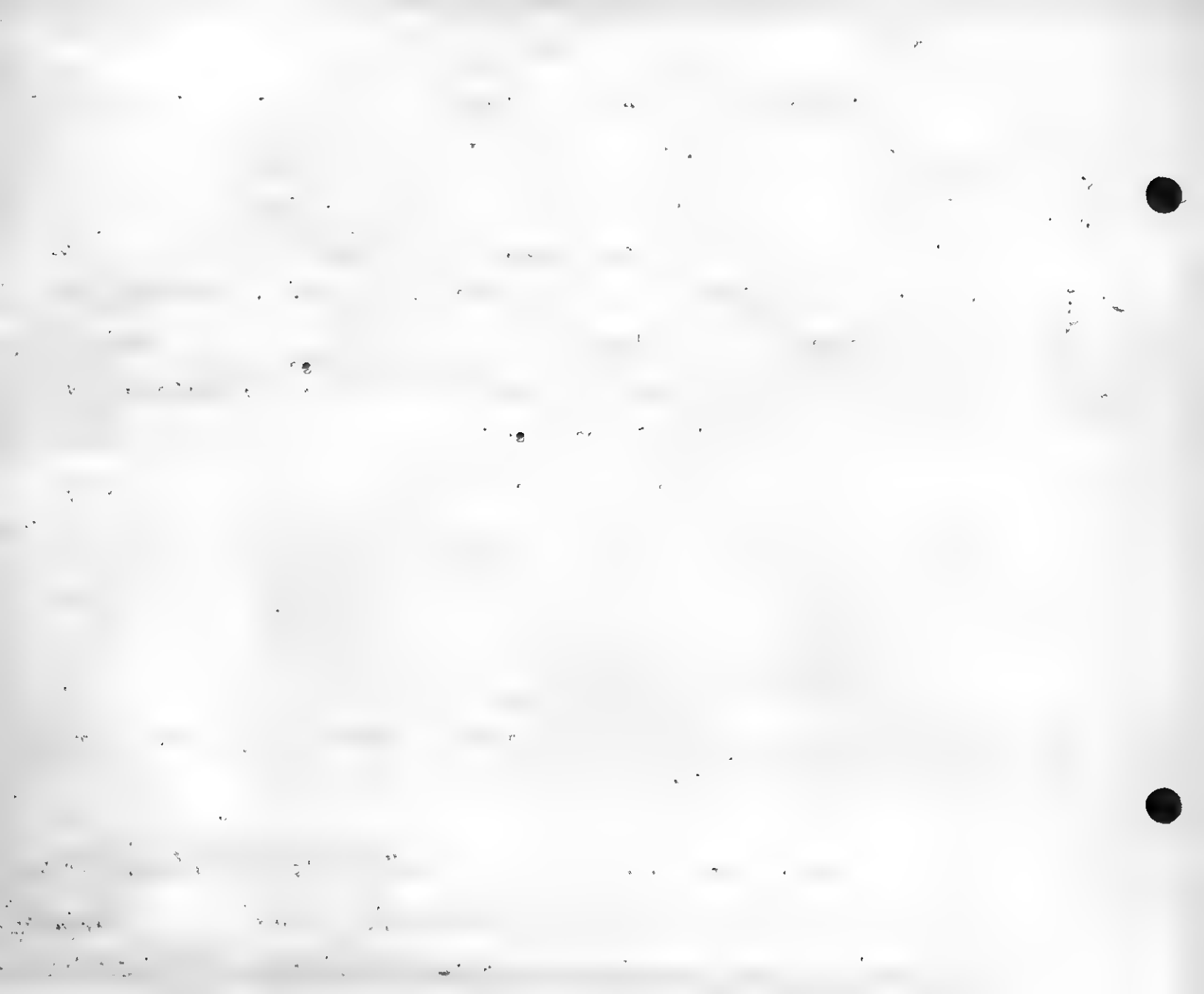
MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH		2b. HOUR	
JOHN			P		O'BRIEN	July 28 1968		Mon	
3 SEX		4 RACE		5. DATE OF BIRTH		6 AGE (In years lost birthday)		IF UNDER 1 YEAR	
male		White		12/10/27		40 YRS.		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)		7b. CIT ZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
DC		USA				Montgomery Md.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
Bethesda		Suburban		Manager		3 M Co			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
md		Mont		Bethesda				6712 Route La	
14 FATHER'S NAME			First	Middle	Last	15 MOTHER'S MAIDEN NAME			First Middle Last
John			A		O'Brien	Kathryn			Lynch
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17 INFORMANT		Address			
Yes		maimed		-		Wife Maida O'Brien Same as above			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinomatosis								6 mos	
1538 DUE TO, OR AS A CONSEQUENCE OF (b) Carcinoma of Colon								11 mos	
CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. (c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
153.8									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
Sept 67		Carcinoma Colon			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		NO		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from March, 1968, to July 28, 1968, that (I) (we) last saw the deceased alive on July 27, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE James W. Egan, M.D.					ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 7/28/68		
22d. PHYSICIAN'S NAME (Type) James W. Egan, M.D.					22e. ADDRESS 5413 Cedar Lane, Bethesda, Maryland				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		7-31-1968		Fort Lincoln Cemetery		Bladensburg, P.G. Co., Md.			
24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc., 5130 Wisc. Ave. N.W., Wash., D.C., 20016					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
					JUL 31 1968		Charles Judge		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/768

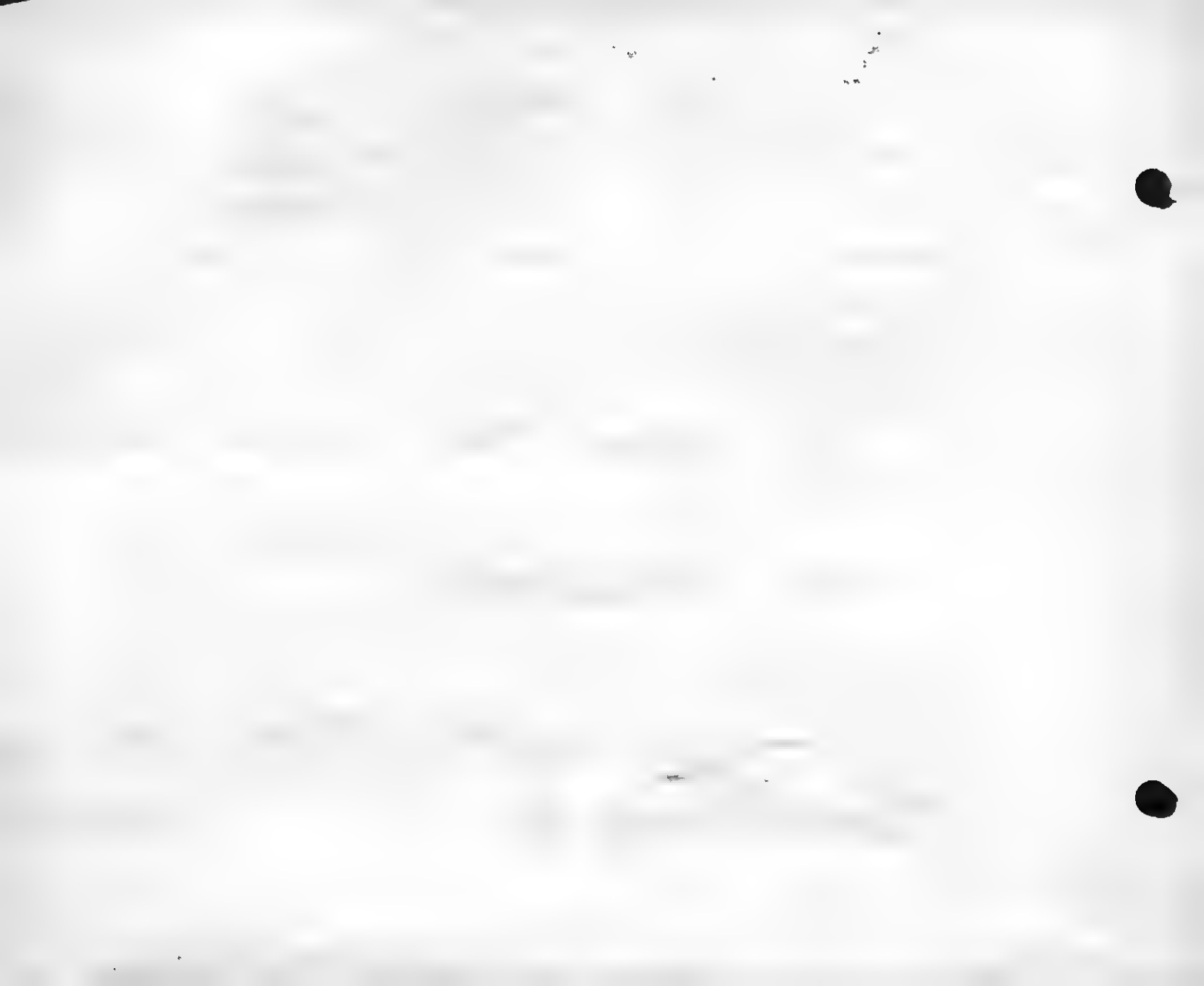
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED NAME (Type or print)			First	Middle	Lost	2a. DATE OF DEATH Month Day Year		2b. HOUR P	
Adrienne			(none)		O'Hara	July 26 1968		8:15 M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years lost birthday)		7. IF UNDER 1 YEAR MONTHS DAYS	
Female		White		7 July 1958		10 YRS			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md	
New York		USA				Montgomery			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
Bethesda		The Clinical Center, NIH		Student		None			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY (M 159) YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Virginia		Fairfax		Falls Church				436 N. Washington Street	
14. FATHER'S NAME			First	Middle	Lost	15. MOTHER'S MAIDEN NAME			First Middle Lost
Charles					O'Hara	Dorothy			Lawson
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			Address
No			None			The Medical Record			The Clinical Center, NIH, Bethesda, Maryland
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))									
PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Staphylococcus Sepsis</u>									
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Acute Lymphocytic Leukemia</u>									
DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
<u>204</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>1 July</u> , 1968, to <u>26 July</u> , 1968, that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <u>26 July</u> , 1968, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death.									
22b. SIGNATURE		22c. DATE SIGNED			22d. PHYSICIAN'S NAME (Type)				
		26 July 1968			Alan L. Snyder, M.D.				
22e. ADDRESS		22f. REGISTRAR'S SIGNATURE							
The Clinical Center, National Institutes of Health, Bethesda, Maryland		J. Charles Judge							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
		July 27, 1968		Calvary Memorial Pk		Fairfax Virginia			
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Pearson's Funeral Home, Falls Church Va		JUL 30 1968							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by filing in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove (properly) pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
CERTIFICATE OF DEATH												
1. DECEASED-NAME (Type or print) <i>Gladys Marie Osborne</i>						2a. DATE OF DEATH Month <i>July</i> Day <i>3</i> Year <i>1968</i>			2b. HOUR <i>6:40 PM</i>			
3 SEX <i>Female</i>		4 RACE <i>White</i>		5. DATE OF BIRTH <i>11/7/90</i>			6. AGE (In years last birthday) <i>77</i> YRS.			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) <i>Mass.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <i>Washington</i> Md.					
10. CITY OR TOWN OF DEATH <i>Bethesda</i>				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban</i>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Housewife</i>			12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution Res. before admission) STATE <i>D.C.</i> <i>Washington</i>				13b. COUNTY <i>Washington</i>		13c. CITY OR TOWN <i>Washington</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>3130 Wisconsin Ave NW</i>		
14. FATHER'S NAME First <i>Arthur</i> Middle <i>Elmer</i> Last <i>Fogg</i>						15. MOTHER'S MAIDEN NAME First <i>Maria</i> Middle <i>Cullen</i> Last <i>Cullen</i>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i>				16b. SOCIAL SECURITY NO <i>—</i>		17. INFORMANT <i>Colonel Ernest L. Osborne - father</i> Address <i>—</i>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Confluent Lobular Pneumonia</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>—</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>—</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <i>490x</i>										APPROXIMATE INTERVAL, BETWEEN ONSET AND DEATH <i>30 days</i>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Chronic Malnutrition</i>												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No		City or Town		County		State		
22a. I certify that (I) (his hospital) attended the deceased from <i>Feb</i> , 19 <i>55</i> , to <i>Jul 3</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>Jul 3</i> , 19 <i>68</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <i>Michael N. Healy MD</i>						ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>Jul 4, 1968</i>				
22d. PHYSICIAN'S NAME (Type) <i>Michael N. Healy, M.D.</i>						22e. ADDRESS <i>Washington Clinic</i>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		23b. DATE <i>JULY 8, 1968</i>		23c. NAME OF CEMETERY OR CREMATORY <i>ROCK CREEK CEM.</i>				23d. LOCATION (City or Town) (County) (State) <i>WASH. D.C.</i>				
24. FUNERAL DIRECTOR <i>H. L. Tol 2222 Wis. Ave NW</i>						25a. REC'D BY REGISTRAR <i>JUL - 9 1968</i>		25b. REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>				



20202

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) ISABELLE M. O'SHEA			2a. DATE OF DEATH Month 7 Day 29 Year 68			2b. HOUR 7:00	
3 SEX FEMALE		4. RACE W		5. DATE OF BIRTH 9/1/00		6. AGE (In years last birthday) 67 YRS.	
7a. BIRTHPLACE (State or foreign country) CALIF.		7b. CITIZEN OF WHAT COUNTRY? U.S.A		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH MONTGOMERY	
10. CITY OR TOWN OF DEATH SILVER SPRING		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) HOLY CROSS HOSP.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) 7705 EA. CLERICAL		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE Md.		13b. COUNTY MONTG.		13c. CITY OR TOWN TAKOMA PARK		13d. INSIDE CITY, I.M.S.? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 7705 EASTERN AVE.		14. FATHER'S NAME First JOHN Middle COFIELD Last ETHEL B. TUPPER.		15. MOTHER'S MAIDEN NAME First ETHEL B. TUPPER. Middle ETHEL B. TUPPER. Last ETHEL B. TUPPER.			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 578-16-9069		17. INFORMANT JOHN E. O'SHEA, SON, 875 WAYNEWOOD		Address BLVD., ALEX. VA.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro-Respiratory Collapse 1870 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) metastatic Renal Cell Carcinoma DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)			
21d. INJURY OCCURRED Where <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from MAY 10, 1968 to JULY 27, 1968 , that (I) (we) last saw the deceased alive on JULY 27, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Bernard A. Heckman, M.D. DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>				22c. DATE SIGNED 7-29-68			
22d. PHYSICIAN'S NAME (Type) BERNARD A. HECKMAN				22e. ADDRESS 8107 EASTERN AVE, SILVER SPRING, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 8-2-1968		23c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery		23d. LOCATION (City or Town) (County) (State) Washington, D.C.	
24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc., 5130 Wisc. Ave. N.W., Wash., D.C., 20016				25a. REC'D BY REGISTRAR AUG 2 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (page 1) and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

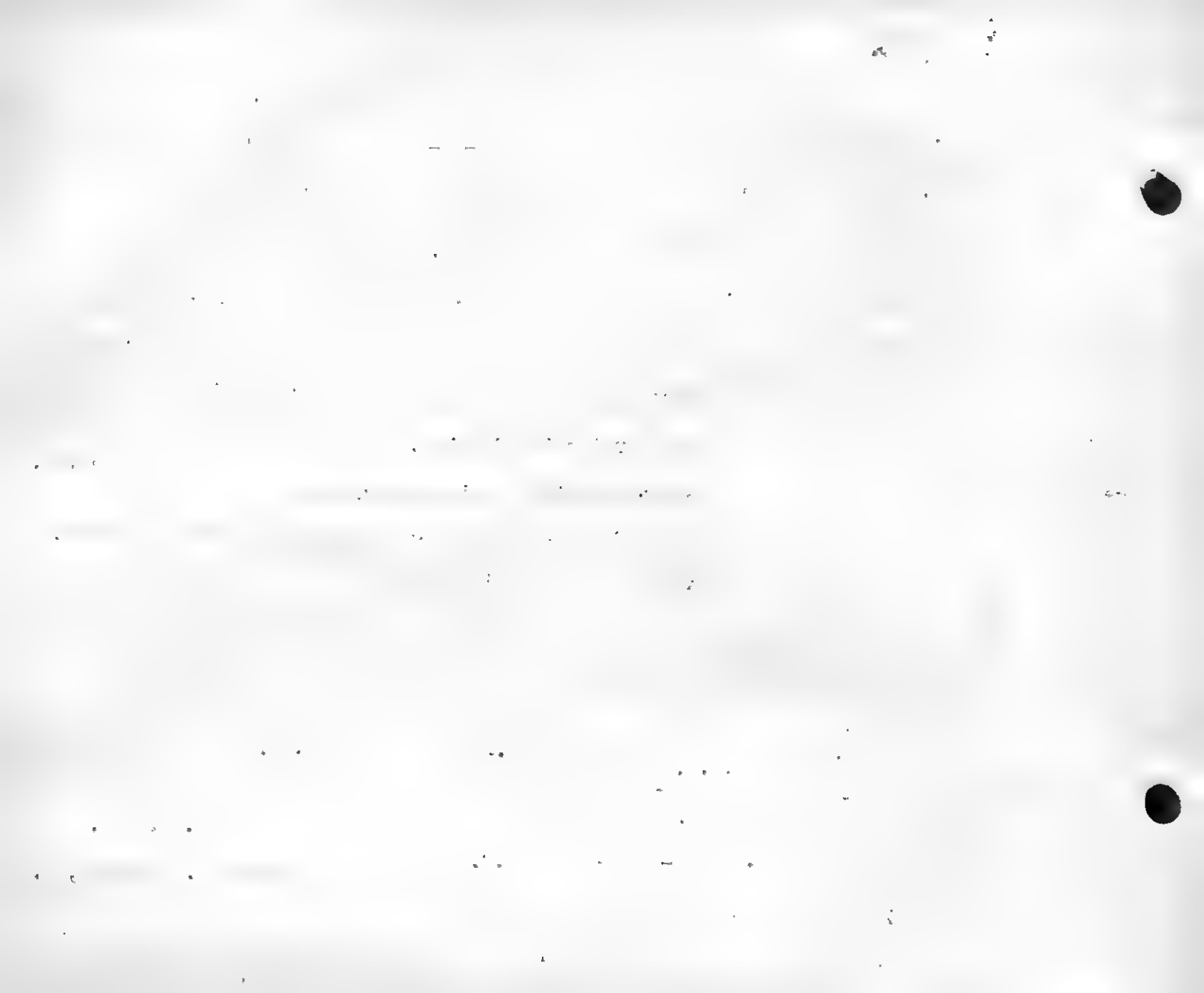
1 DECEASED-NAME (Type or print) Mary Lou Ostrom			2a. DATE OF DEATH Month July Day 6 Year 1968			2b. HOUR 8:40 P M	
3 SEX Female		4 RACE White		5. DATE OF BIRTH 10 April 1954		6 AGE (In years last birthday) 14 YRS.	
7a BIRTHPLACE (State or foreign country) Michigan		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md	
10 CITY OR TOWN OF DEATH Bethesda		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) The Clinical Center, NIH		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Student		12b. KIND OF BUSINESS OR INDUSTRY None	
13a. USUAL RESIDENCE (Where deceased lived, if institut an admission) STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Gaithersburg		13d. INS. DE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 203 Lee Street							
14 FATHER'S NAME First Harold Middle Ostrom Last Ostrom			15 MOTHER'S MAIDEN NAME First Joyce Middle Allen Last Allen				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No (If yes give war or dates of service)		16b. SOCIAL SECURITY NO None		17 INFORMANT The Medical Record Address The Clinical Center, NIH, Bethesda, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Pseudomonas Septicemia DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Acute Myelogenous Leukemia DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 months 11 months							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 12 May , 19 68 , to 6 July , 19 68 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 6 July , 19 68 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) <input checked="" type="checkbox"/> (did not) view the body after death.							
22b. SIGNATURE Robert E. Gallagher DEGREE Robert E. Gallagher, M.D.				ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED 6 July 1968	
22d. PHYSICIAN'S NAME (Type) Robert E. Gallagher, M.D.				22e. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Maryland			
23a. BURIAL, CREMATION, or other disposal Burial		23b. DATE 7-8-68		23c. NAME OF CEMETERY OR CREMATORY W.C. Chambers Co. 3072 - M St vi		23d. LOCATION (City or Town) (County) (State) Tarhan Spring Hs.	
24. FUNERAL DIRECTOR W.C. Chambers Co.				25a. REC'D BY REGISTRAR JUL - 9 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1 DECEASED NAME (Type or print) MYKOLA				First Middle Last PACZOWSKYJ				2a DATE OF DEATH Month Day 68		2b HOUR 7:10A	
3 SEX Male		4 RACE White		5. DATE OF BIRTH 1-22-94		6 AGE (in years last birthday) 74 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Ukraine		7b. CITIZEN OF WHAT COUNTRY? Polish		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Montgomery					
10 CITY OR TOWN OF DEATH Takoma Park				11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington San & Hosp.				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Grocer		12b KIND OF BUSINESS OR INDUSTRY Retail	
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland				13b COUNTY Montgomery		13c CITY OR TOWN Takoma Pk.		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 7004 Sycamore Ave.	
14. FATHER'S NAME First Middle Last JAROSLAV Paczowskyj				15 MOTHER'S MAIDEN NAME First Middle Last MARIA Kawinska							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No (If yes give war or dates of service)				16b SOCIAL SECURITY NO. 578468381		17. INFORMANT 7004 Sycamore Avenue Ostap Zynjuk Takoma Park, Maryland					
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute cardiac insufficiency 2509 DUE TO, OR AS A CONSEQUENCE OF (b) Diabetes mellitus with generalized DUE TO, OR AS A CONSEQUENCE OF (c) cerebrovascular, coronary and peripheral arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 yrs.	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) as above and cardiac asthma											
9a. DATE OF OPERATION		9b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 6.25 , 19 68 , to 7.16 , 19 68 , that (I) (we) last saw the deceased alive on 9 p.m. 7/16/ 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Stanley A. Radwan-Ziemnowicz		DEGREE		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 7.17.1968.					
22d. PHYSICIAN'S NAME (Type) Stanley A. RADWAN-ZIEMNOWICZ, M.D.		22e. ADDRESS 9400 Old Georgetown Rd. Bethesda, Md.									
23a. BURIAL, CREMATION, RENEGAL (Specify)		23b. DATE 7/20/1968		23c. NAME OF CEMETERY OR CREMATORY Mt Olivet Cemetery				23d. LOCATION (City or Town) (County) (State) Washington, D.C.			
24. FUNERAL DIRECTOR Valley Funeral Home Mt. Rainier, Md.				ADDRESS		25a. REC'D BY REGISTRAR DATE JUL 22 1968		25b. REGISTRAR'S SIGNATURE Charles J. J...			



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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1 DECEASED-NAME (Type or print) <u>Albert T. Phillips</u>						2a DATE OF DEATH <u>July 21, 1968</u>			2b HOUR <u>10 P M</u>		
3 SEX <u>male</u>		4 RACE <u>white</u>		5 DATE OF BIRTH <u>4/4/98</u>		6 AGE (In years last birthday) <u>70</u> YRS.		7 UNDER 1 YEAR MONTHS DAYS		8 IF UNDER 24 HRS. HOURS MIN.	
7a BIRTHPLACE (State or foreign country) <u>md.</u>		7b CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <u>Montgomery</u> Md.					
10 CITY OR TOWN OF DEATH <u>Bethesda</u>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>suburban</u>				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b KIND OF BUSINESS OR INDUSTRY		
13a USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE <u>md.</u>		13b COUNTY <u>Mont.</u>		13c CITY OR TOWN <u>Bethesda</u>		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER <u>5412 - Burlingame</u>			
14 FATHER'S NAME First <u>HUGH</u> Middle <u>W.B.</u> Last <u>PHILLIPS</u>				15 MOTHER'S MAIDEN NAME First <u>SIDNEY</u> Middle <u>W.B.</u> Last <u>Benjamin</u>							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes (no or unknown) <u>Yes</u> (If yes give war or dates of service) <u>W.W.II - Army</u>				16b SOCIAL SECURITY NO. <u>N.A.</u>		17. INFORMANT <u>1416 Crestview Dr. Address Blacksburg, Va. Mrs. Nancy P. Leach, Daughter,</u>					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Uremia</u>										<u>2-Weeks</u>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <u>420</u>										DUE TO, OR AS A CONSEQUENCE OF (b) <u>Renal circulatory failure</u> <u>2 Weeks</u>	
										DUE TO, OR AS A CONSEQUENCE OF (c) <u>Myocardial infarct heart failure</u> <u>1 Month</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Arteriosclerosis - General</u>											
19a DATE OF OPERATION <u>none</u>		19b CONDITION FOR WHICH OPERATION WAS PERFORMED <u>none</u>		20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b IF YES WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>No</u>					
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. <u>19</u>		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18.)							
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f LOCATION Street or R.F.D. No		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from <u>June 1, 1960</u> to <u>July 21, 1968</u> , that (I) (we) last saw the deceased alive on <u>July 21, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b SIGNATURE <u>Frank S. Bacon M.D.</u> DEGREE				ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c DATE SIGNED <u>July 21, 1968</u>					
22d PHYSICIAN'S NAME (Type) <u>Frank S. Bacon</u>				22e ADDRESS <u>2141 K St. N.W., Wash., D.C.</u>							
23a BURIAL, CREMATION REMOVAL (Specify)		23b DATE <u>7-23-1968</u>		23c NAME OF CEMETERY OR CREMATORY <u>Oak Hill Cemetery</u>		23d LOCATION (City or Town) (County) (State) <u>Washington, D.C.</u>					
24 FUNERAL DIRECTOR <u>Joseph Gawler's Sons, Inc., 5130 Wisc. Ave. N.W., Wash., D.C., 2016</u>				25a REC'D BY REGISTRAR DATE <u>JUL 26 1968</u>		25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>					



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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH			2b. HOUR
Janice Elaine Pierce						Month Day Year July 18 1968			8:20 M
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. IF UNDER 1 YEAR	
Female		White		17 January 1945		23 YRS		MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Ohio		USA				Montgomery Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
Bethesda			The Clinical Center, NIH			Medical Technologist		Medicine	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		3d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER
Maryland			Prince Georges		Adelphi		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		9280 Adelphi Road
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last Robert Pierce			First Middle Last Marion Wolcott						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT				
No			Not available		The Medical Record Address The Clinical Center, NIH, Bethesda, Maryland				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gram Negative Septicemia</u>									Hours
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Aplastic Anemia</u>									1 year
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
1124									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
June 7, 1968		Partial Bowel Necrosis			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		Yes		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, item 1B.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION		Street or R.F.D. No		City or Town	County State
22a. I certify that (A) (this hospital) attended the deceased from <u>17 Feb.</u> , 1968, to <u>18 July</u> , 1968, that (A) (we) last saw the deceased alive on <u>18 July</u> , 1968, and that in (A) (our) opinion death occurred on the date and hour and from the causes stated above, (A) (we) (did) (did not) view the body after death.									
22b. SIGNATURE						22c. DATE SIGNED			
Alan L. Snyder, M.D.						18 July 1968			
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS			
The Clinical Center, National Institutes of Health, Bethesda, Maryland									
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)	(State)
Removal		7/18/68		Grove St. Cem.		New London		Huron	Ohio
24. FUNERAL DIRECTOR						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Robert A. Pumphrey, Bethesda, Maryland						JUL 22 1968		J Charles Jones	



4

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VR A15 (7)
30M REV 1/68

20307												DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
Item #4, Film G103 7/31/68 km												CERTIFICATE OF DEATH											
1 DECEASED-NAME (Type or print) <i>Mary</i> First <i>Plummer</i> Middle Last						2a DATE OF DEATH Month <i>July</i> Day <i>16</i> Year <i>68</i>						2b HOUR <i>3:30</i> M											
3 SEX <i>Female</i>				4 RACE <i>Negro</i>				5 DATE OF BIRTH <i>3/18/03</i>				6 AGE (in years last birthday) <i>66</i> YRS.				7 UNDER 1 YEAR MONTHS DAYS				8 UNDER 24 HRS HOURS MIN.			
7a BIRTHPLACE (State or foreign country) <i>md.</i>				7b CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>				8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH <i>Montgomery</i> Md.											
10 CITY OR TOWN OF DEATH <i>Bethesda</i>				11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <i>Suburban</i>				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Homemaker</i>				12b KIND OF BUSINESS OR INDUSTRY <i>Private</i>											
13a USUA. RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <i>md.</i>						13b COUNTY <i>Montgomery</i>		13c CITY OR TOWN <i>Boyd's</i>		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER <i>Boulevard 1-Box 143</i>											
14 FATHER'S NAME First <i>Unknown</i> Middle Last						15 MOTHER'S MAIDEN NAME First <i>Unknown</i> Middle Last																	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown						16b. SOCIAL SECURITY NO						17 INFORMANT <i>Charles M. Plummer</i> 302 Address <i>Mat. Perry</i> <i>md.</i>											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))																		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>ACUTE MYELOGENOUS LEUKEMIA</i>																		<i>3 MON.</i>					
2000 DUE TO, OR AS A CONSEQUENCE OF																							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>2 4 3</i>																		DUE TO, OR AS A CONSEQUENCE OF					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>DIABETES AND A.S.H.T.D.</i>																							
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>				20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)															
21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work				21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)				21f. LOCATION Street or R.F.D. No. City or Town County State															
22a. I certify that (I) (this hospital) attended the deceased from <i>MAY 19, 1968</i> , to <i>JULY 16, 1968</i> , that (I) (we) last saw the deceased alive on <i>JULY 16, 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																							
22b. SIGNATURE <i>Robert C. Daddario MD</i> DEGREE												ATTENDING PHYS. <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>				22c. DATE SIGNED <i>7/17/68</i>							
22b. PHYSICIAN'S NAME (Type) <i>ROBERT C. DADDARIO</i>												22e. ADDRESS <i>5413 CEDAR LANE BETHESDA</i>											
23a. BURIAL, CREMATION, OR REMOVAL (Specify)				23b. DATE <i>7-20-68</i>				23c. NAME OF CEMETERY OR CREMATORY <i>St. Mark Church Cem.</i>				23d. LOCATION (City or Town) (County) (State) <i>Boyd's Montgomery md.</i>											
24. FUNERAL DIRECTOR <i>Robert L. Snowden</i> ADDRESS <i>Rockville Md.</i>												25a. REC'D BY REGISTRAR DATE <i>JUL 25 1968</i>				25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>							



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
10308											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month		Day	Year	2b. HOUR A. M.	
Nathan			(NMN)		Podolsky	July		9	1968	5:10	
3 SEX		4 RACE		5. DATE OF BIRTH		6 AGE (In years last birthday)		7. NUMBER 1 YEAR MONTHS		IF UNDER 24 HRS DAYS	
Male		White		January 1, 1893		75		YRS		MMN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.			
Russia		America				Montgomery					
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
Takoma Park			Washington Sanitarium			Tailor		CLOTHING			
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) - STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIM TS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER		
Maryland			Montgomery		Silver Spring		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		8105n Eastern Avenue		
14 FATHER'S NAME			First	Middle	Last	15 MOTHER'S MAIDEN NAME			First	Middle	Last
Abraham			:		Podolsky	Laura					?
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			(If yes give war or dates of service)			16b. SOCIAL SECURITY NO			17 INFORMANT		
no			-			64-09-7681			Patient's chart		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Heart Failure</u>										Days	
DUE TO, OR AS A CONSEQUENCE OF											
Conditions if any, which gave rise to immediate cause (a) stating the underlying cause last										(b) <u>arteriosclerotic heart disease</u>	
DUE TO, OR AS A CONSEQUENCE OF										(c) <u>yes</u>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
4. <u>Diabetic Mellitus</u> <u>Previous Cardiovascular</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)			21f. LOCATION Street or R.F.D. No		City or Town		County		State
22a. I certify that (I) (this hospital) attended the deceased from <u>OCT 1, 1965</u> , to <u>JULY 9, 1965</u> , that (I) (we) last saw the deceased alive on <u>JULY 9, 1965</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Albert H. Grollman</u> DEGREE						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>7/9/68</u>			
22d. PHYSICIAN'S NAME (Type) <u>ALBERT H. GROLLMAN</u>						22e. ADDRESS <u>1106 SPRING ST. SILVER</u>					
23a. BURIAL CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		County		State	
<u>BURIAL</u>		<u>7-11-68</u>		<u>GEORGE WASH CEM.</u>		<u>HYATTSVILLE</u>		<u>MD.</u>		<u>MD.</u>	
24 FUNERAL DIRECTOR						ADDRESS <u>200 H</u>		25a. REC'D BY REGISTRAR DATE <u>JUL 15 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
<u>Goldberg Funeral Home 4217 9th NW, Wash, D.C.</u>											



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1 DECEASED-NAME (Type or print) <u>Jesse</u> First <u>G.</u> Middle <u>Poffenbarger</u> Last						2a. DATE OF DEATH <u>July 31</u> 19 <u>68</u> Month <u>July</u> Day <u>31</u> Year <u>1968</u>			2b. HOUR <u>8:54</u> AM		
3. SEX <u>Male</u>		4. RACE <u>CAUCASIAN</u>		5. DATE OF BIRTH <u>JAN 24-1888</u>		6. AGE (In years last birthday) <u>80</u> YRS.		7. FINDER 1 YEAR MONTHS <u>8</u> DAYS <u>15</u>		IF UNDER 24 HRS. HOURS <u>15</u> MIN.	
7a. BIRTHPLACE (State or foreign country) <u>Maryland</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <u>Montgomery Co.</u> Md					
10. CITY OR TOWN OF DEATH <u>Bethesda</u>				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>GEOSUNOR HANE NURSING HOME</u>				12a. USUAL OCCUPATION (Kind of work done during most of waking life even if retired) <u></u>		12b. KIND OF BUSINESS OR INDUSTRY <u></u>	
13a. USUAL RES. (Where deceased lived, if institution. Residence before admission) STATE <u>MARYLAND</u>				13b. COUNTY <u>Montgomery</u>		13c. CITY OR TOWN <u>Bethesda</u>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <u>4612 Maple Avenue</u>	
14. FATHER'S NAME First <u>William</u> Middle <u>H.</u> Last <u>Poffenbarger</u>				15. MOTHER'S MAIDEN NAME First <u>Marion</u> Middle <u></u> Last <u>Barnes</u>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <u>No.</u> (If yes give war or dates of service)				16b. SOCIAL SECURITY NO. <u>705-10-2316</u>		17. INFORMANT Address <u>Mrs. Katherine Dagenhart, Rohrsersville, Md.</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cachexia.</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Squamous cell carcinoma of pharynx.</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2-3 mos.</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>1483</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <u>19</u>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME FARM, STREET FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <u>July 8, 1966</u> to <u>July 31, 1968</u> , that (I) (we) last saw the deceased alive on <u>July 27, 1968</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. <u>at 8:50 A.M.</u>											
22b. SIGNATURE <u>George I. Gray, Jr. M.D.</u>		22c. DATE SIGNED <u>July 31, 1968</u>		22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS <u>4740 Cherry Chase Drive, Chevy Chase, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>8-3-68</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rohrsersville Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Rohrsersville, Wash. Co., Md.</u>					
24. FUNERAL DIRECTOR <u>John H. Bast, Jr.</u> ADDRESS <u>112 N. Main St. Boonsboro, Md.</u>				25a. REC'D BY REGISTRAR <u>AUG 2 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>					

MEDICAL CERTIFICATION



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN lb <u>3 Mos.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>7720 Sebago Road.</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Samuel's 1st New York</u> b. COUNTY <u>Kings</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Brooklyn</u> d. STREET ADDRESS <u>110 Shore Blvd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First Middle Last <u>Sam - Pollin</u>		4. DATE OF DEATH Month Day Year <u>7 16 1968</u>		5. SEX <u>M</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1/20/87</u>		9. AGE (In years last birthday) <u>81</u> yrs. IF FUNOER 1 YEAR IF FUNOER 24 HRS. Months Oays Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laundry Worker</u> 10b. KIND OF BUSINESS OR INDUSTRY _____				11. BIRTHPLACE (County & State, or foreign country) <u>Russia</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>									
13. FATHER'S NAME <u>Joseph Pollin</u>				14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>									
15. WAS DECEASED EVER IN U.S. ARMY OR FORCES? Yes, no, or (unknown) <u>Yes</u> (If yes give war or dates of service) <u>WW I</u>				16. SOCIAL SECURITY NO. <u>101-95-0814</u>		17. INFORMANT <u>William Pollin</u>		Address <u>Bethesda MD</u> <u>7720 Sebago Rd.</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO (b) <u>Atherosclerotic Cardiovascular Disease</u> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>10 yrs</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>NONE</u>										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)						
21. I certify that (I) (this hospital) attended the deceased from <u>JAN 16, 1966</u> , to <u>JULY 16, 1968</u> , that (I) (we) last saw the deceased alive on <u>NOV 3, 1967</u> , and that death occurred at <u>8:00</u> AM, from the causes and on the date stated above.													
22a. SIGNATURE <u>Stephen W. DeJter</u>				22b. DATE SIGNED <u>JULY 16, 1968</u>		22c. PHYSICIAN'S NAME (Type) <u>STEPHEN W. DEJTER, M.D.</u>		22d. ADDRESS <u>6719 WILSON LANE, BETHESDA, MD 20834</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>			23b. DATE THEREOF <u>7/18/1968</u>		23c. NAME OF CEMETERY OR CREMATORY <u>NATL. MEM. PARK</u>			23d. LOCATION (City, town or county) (State) <u>FALLS CHURCH VA.</u>					
24. FUNERAL DIRECTOR <u>GOLD 3035</u>				25a. REC'D BY REGISTRAR <u>JUL 19 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>							

MEDICAL CERTIFICATION



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PW-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-inquest (if it) File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or Print) HOW KEE PONG						2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> Month 7 Day 16 Year 1968						2b. HOUR 6:45 PM	
3 SEX Male	4 RACE Yellow	5 DATE OF BIRTH Dec. 25, 1910	6 AGE (In years last birthday) 57 YRS	IF UNDER 1 YEAR MONTHS 0 DAYS 0	F UNDER 24 HRS HOURS 0 MIN 0	2c. DATE PRONOUNCED DEAD Month 7 Day 16 Year 1968						2d. HOUR 6:45 PM	
7a. BIRTHPLACE (State or foreign country) China		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.							
10. CITY OR TOWN OF DEATH Takoma Park, Md.			11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Wash. San. & Hosp. Restaurant Operator			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY				
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before death) Hyattsville, Md.			13b. COUNTY P. George Hyatts.,			13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13d. STREET AND NUMBER 906 Chillum Rd.				
14. FATHER'S NAME Hong Lee						15. MOTHER'S MAIDEN NAME Unknown							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16b. SOCIAL SECURITY NO. (If yes give year or dates of service)			17. INFORMANT Alfred Pong - Son ADDRESS Same as #13							
18. CAUSE OF DEATH (Enter only one cause per line, (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Generalized Metastatic 1990 DUE TO, OR AS A CONSEQUENCE OF (b) Carcinoma including Liver DUE TO, OR AS A CONSEQUENCE OF (c) and Internal Organs										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR A.M. 19 P.M.				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE Belden R. Keapin				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED July 16, 1968					
EXAMINER'S NAME (Type) BELDEN R. KEAPIN, M.D.				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				ADDRESS (Street, City, Town, or County)					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 7-21-1968		23c. NAME OF CEMETERY OR CREMATORY George Wash. Memo. Cem.		23d. LOCATION (City or Town) (County) (State) Hyattsville, Maryland		25a. REC'D BY REGISTRAR JUL 22 1968					
24. FUNERAL DIRECTOR Lee Funeral Home-300 4th St. NE Wash. DC						25b. REGISTRAR'S SIGNATURE J. Charles Judge							



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 18, 22a film 403 Maryland State Department of Health
8-6-68 mt. DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10012 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED NAME (Type or Print) First Middle Last KEITH ANTHONY PRATHER			2a DATE KNOWN OF EST. DEATH MATED <input type="checkbox"/> Month <input checked="" type="checkbox"/> Day <input type="checkbox"/> Year 1968 7-21			2b HOUR 11:30 AM	
3 SEX M	4 RACE N	5 DATE OF BIRTH 6-7-68	6 AGE (In years last birthday) 1 YRS MONTHS 1 DAYS 1	IF UNDER 1 YEAR HOURS 1 MIN 1		2c DATE PRONOUNCED DEAD Month 7 Day 21 Year 1968	
7a BIRTHPLACE (State or foreign country) DC		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Montgomery	
10 CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Washington San & Hosp.		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY	
3a USJA. RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland		13b CITY OR TOWN Takoma Pk.		13a. ASIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 7620 Maple Ave	
14 FATHER'S NAME First Middle Last Sylvester Kermit Prather			15 MOTHER'S MAIDEN NAME First Middle Last Shirley Anne Diggs				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16b SOCIAL SECURITY NO (If yes give war or dates of service)		17. INFORMANT ADDRESS Father Same			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Pneumonitis of probable Viral 480X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) etiology DUE TO, OR AS A CONSEQUENCE OF (c) SDII							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)							
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b TIME OF INJURY Month, Day, Year HOUR A.M. 19 P.M.		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No City or Town County State			
22a I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Belden K. Reap		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED July 21, 1968	
EXAMINER'S NAME (Type) BELDEN K. REAP, M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		ADDRESS (Street, City, Town, or County) Rockville Montg Md.			
23a BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b DATE 7-26-68		23c NAME OF CEMETERY OR CREMATORY Lincoln Park Cem		23d LOCATION (City or Town) (County) (State) Rockville Montg Md.	
24 FUNERAL DIRECTOR Robert L. Snowden				ADDRESS Rockville Md.		25a REC'D BY REGISTRAR JUL 29 1968	
				25b REGISTRAR'S SIGNATURE J. Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

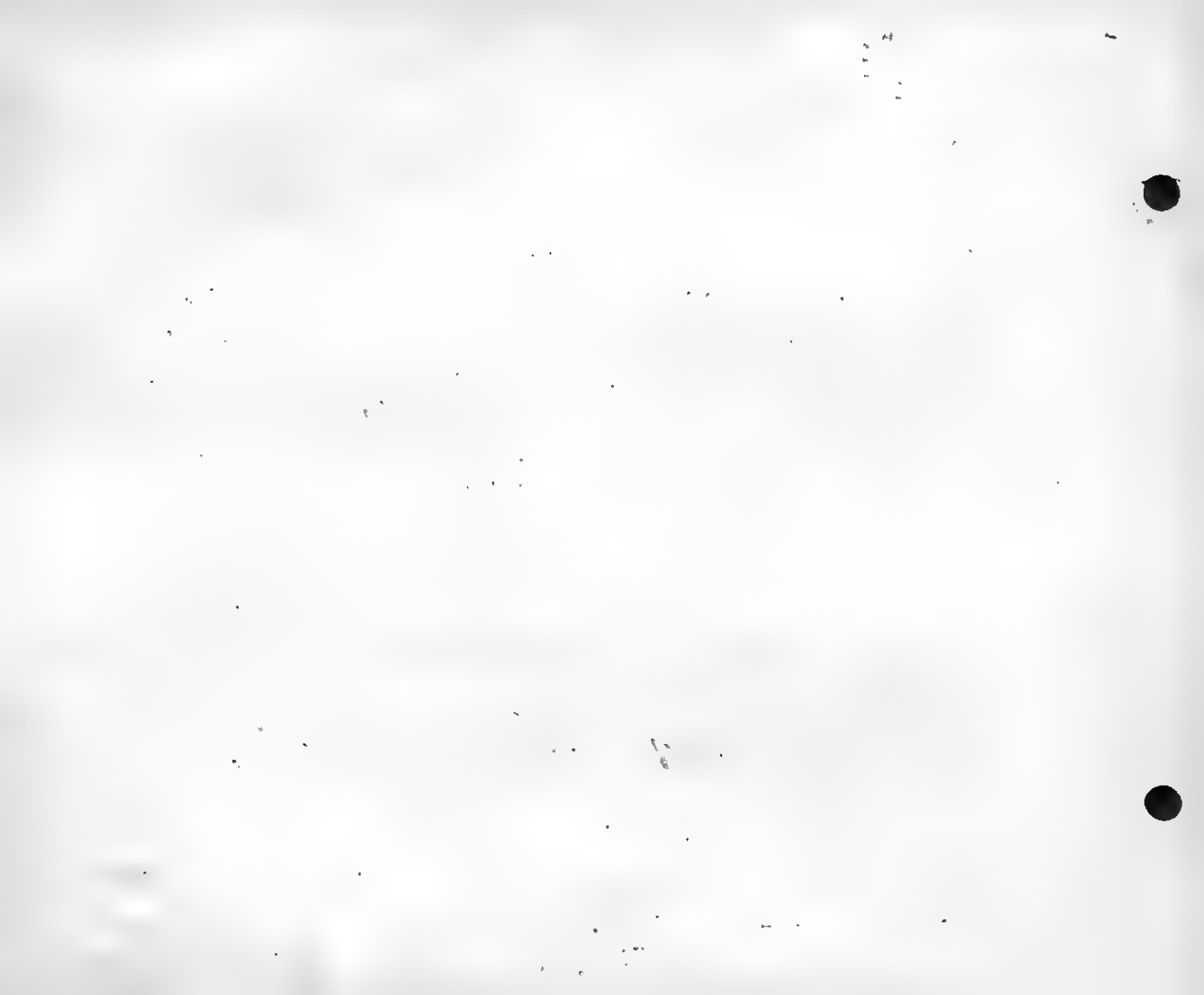
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1 DECEASED NAME (Type or print)			First Middle Last			2a DATE OF DEATH		2b HOUR		
JOHN S PRIVOTT						JULY 5 1968		7:57 PM		
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER 1 YEAR		
MALE		WHITE		6-6-1900		68 YRS		MONTHS DAYS HOURS MIN		
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9 COUNTY OF DEATH				
NC.		USA				Montgomery Md				
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, except retired)		12b KIND OF BUSINESS OR INDUSTRY		
Kensington			Kensington Gardens San			Barber		Cabinetmaking		
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE			13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER	
Maryland			Mont.		Silver Spring		YES		8307-16th St.	
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME							
JOHN S PRIVOTT			SALLY WARD							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b SOCIAL SECURITY NO		17 INFORMANT					
No			577-05-0966		Wesley M. McKee Silver Spring Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY:										
IMMEDIATE CAUSE (a) <u>malnutrition</u>									3 mo	
DUE TO, OR AS A CONSEQUENCE OF (b) <u>advanced arteriosclerosis</u>									5 yrs.	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										
DUE TO, OR AS A CONSEQUENCE OF (c)										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
4301										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
					YES <input type="checkbox"/> NO <input type="checkbox"/>		no			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
		HOUR A.M. Month Day Year P.M. 19								
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f LOCATION		Street or R.F.D. No		City or Town County State		
22a. I certify that (I) (this hospital) attended the deceased from 1965, to 7-5, 1968, that (I) (we) last saw the deceased alive on 7-5, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b SIGNATURE					ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED			
G. F. SENGSTACK							7-5-68			
22d: PHYSICIAN'S NAME (Type)					22e ADDRESS					
G. F. SENGSTACK					4241 Col Blvd Silver Spring Md.					
23a BURIAL, CREMATION, OR OTHER (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Burial		7-8-68		7th Lincoln		Bladensburg Md				
24. FUNERAL DIRECTOR		ADDRESS		25a RECD BY REGISTRAR		25b REGISTRAR'S SIGNATURE				
C. W. Chambers		Silver Spring Md		JUL - 9 1968		J. Charles Judge				



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MONTGOMERY DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 Item 6 Film 610 8/27/68													
CERTIFICATE OF DEATH													
1. DECEASED NAME (Type or print) George			First F.		Middle F.		Last Race		2a. DATE OF DEATH Month July Day 27 Year 1968		2b. HOUR 12:30p		
3. SEX Male		4. RACE White		5. DATE OF BIRTH 12/3/22			6. AGE (in years last birthday) 46 1/2 YRS.			IF UNDER 1 YEAR MONTHS 1		IF UNDER 24 HRS. DAYS 1	
7a. BIRTHPLACE (State or foreign country) Indiana		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Montgomery Md.						
10. CITY OR TOWN OF DEATH Bethesda			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Suburban			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Retired			12b. KIND OF BUSINESS OR INDUSTRY USGovt				
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE MD.			13b. COUNTY Montgomery			13c. CITY OR TOWN Bethesda		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 3 Pooks Hill Rd.			
14. FATHER'S NAME First Francis Middle Louis Last Race			15. MOTHER'S MAIDEN NAME First Frances Middle Mulford Last										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown Army WWII			16b. SOCIAL SECURITY NO. Yes			17. INFORMANT Name John H Chase Jr Address 8562 Freyman DR Chevy Chase, Md							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hepatic failure DUE TO, OR AS A CONSEQUENCE OF cirrhosis (b) alcoholism DUE TO, OR AS A CONSEQUENCE OF alcoholism (c) alcoholism Approximate interval between onset and death: years													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 5811													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)							
21d. INJURY OCCURRED Where <input type="checkbox"/> Not where <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No City or Town County State April 68 7/27/68 68							
22a. I certify that (I) (this hospital) attended the deceased from April 68 7/27/68 , 19 68 , that (I) (we) last saw the deceased alive on 7/27/68 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE Jay Shapiro			DEGREE MD			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED 7/27/68				
22d. PHYSICIAN'S NAME (Type) JAY SHAPIRO			22e. ADDRESS 8218 Wisc. Ave. Bethesda, Maryland										
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE 8-1-68			23c. NAME OF CEMETERY OR CREMATORY Balt. Nat Cemetery			23d. LOCATION (City or Town) (County) (State) Baltimore City Md				
24. FUNERAL DIRECTOR Robert A Pumphrey			7557 Wisconsin Ave Bethesda, Md			25a. REC'D BY REGISTRAR DAUG 2 1968			25b. REGISTRAR'S SIGNATURE Charles Judge				



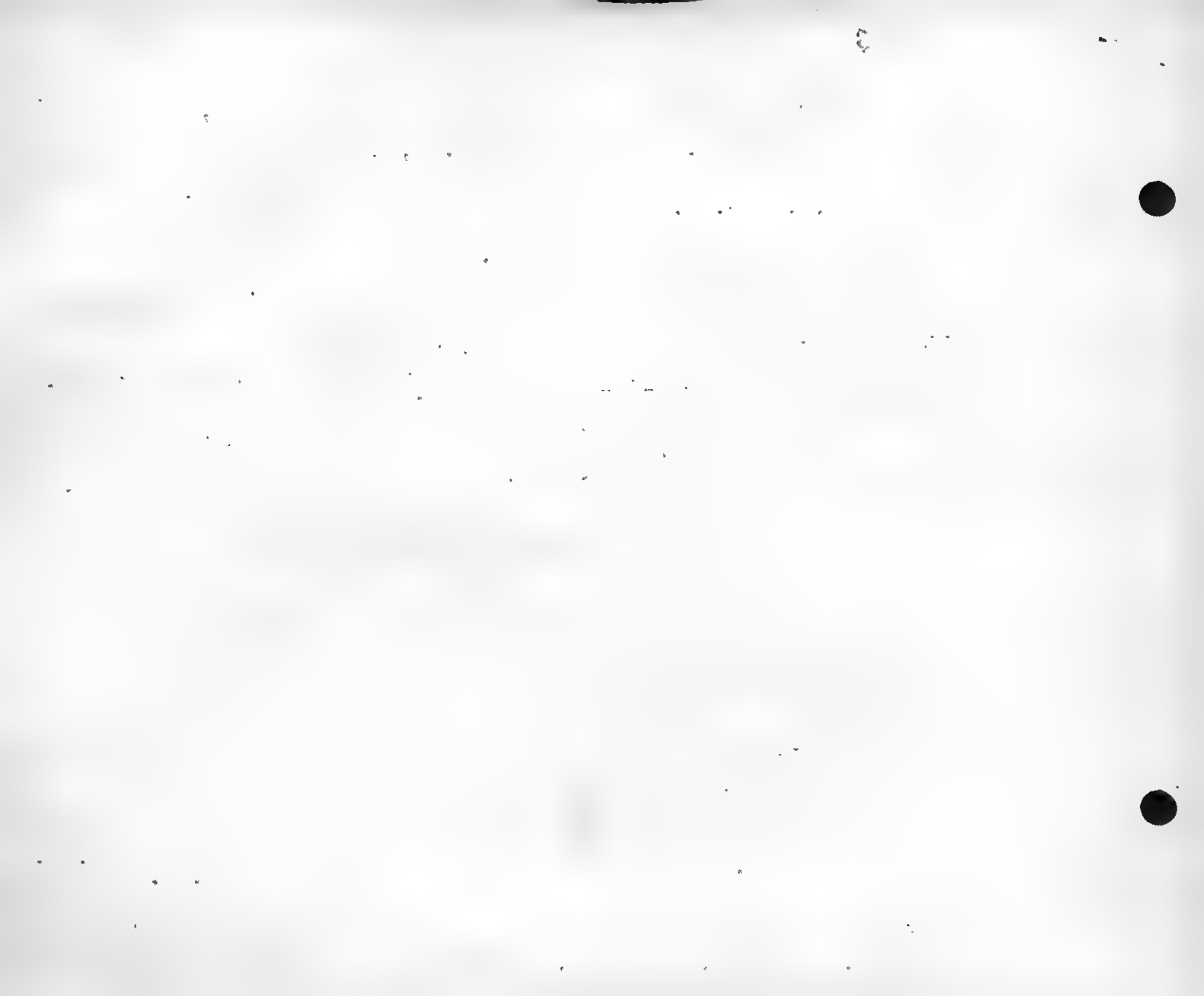
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VR A15 (4)
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1 DECEASED-NAME. (Type or print) JOHN DIGGES REEVES			2a. DATE OF DEATH Month July Day 4 Year 1968			2b. HOUR 2:10 P			
3 SEX Male		4. RACE Cauc.		5. DATE OF BIRTH Dec. 7, 1921		6. AGE (In years last birthday) 46 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Washington, D.C.		7b. CITIZEN OF WHAT COUNTRY? U. S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.			
10 CITY OR TOWN OF DEATH Rockville		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 1387 Kimblewick Road		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Candy Broker		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 1387 Kimblewick Road	
14. FATHER'S NAME First Middle Last Edward Reeves			15. MOTHER'S MAIDEN NAME First Middle Last Ellen Haslan						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown Yes		16b. SOCIAL SECURITY NO WW 11 577-22-2189		17 INFORMANT Wife Address Wanda V. Reeves Same as Item 13.					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIO SCLEROTIC CV DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) with Hypertension								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Months several yrs	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (the hospital) attended the deceased from 1961 to July 4, 1968 , that (I) (we) last saw the deceased alive on June 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE DeWitt E. DeLawter		22c. DATE SIGNED July 4, 1968		22d. PHYSICIAN'S NAME (Type) DeWitt E. DeLawter		22e. ADDRESS 3848 Porter Street, N. W. Washington, D. C.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 7-8-68		23c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery		23d. LOCATION (City or Town) (County) (State) Rockville, Maryland			
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Maryland		25a. REC'D BY REGISTRAR JUL 11 1968		25b. REGISTRAR'S SIGNATURE Charles Judge					



**FOR STATE
HEALTH DEPT.**

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Items 18&22a Film 403
19-68 ans DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED NAME (Type or Print) <u>Allen</u> <u>(None)</u> <u>Register</u>			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <u>7</u> Day <u>29</u> Year <u>1968</u>			2b. HOUR <u>1:05</u> AM <input type="checkbox"/> PM		
3. SEX <u>male</u>	4. RACE <u>white</u>	5. DATE OF BIRTH <u>4-12-86</u>	6. AGE (In years last birthday) <u>82</u> YRS	IF UNDER 1 YEAR MONTHS <u> </u> DAYS <u> </u>	IF UNDER 24 HRS HOURS <u> </u> MIN <u> </u>	2c. DATE PRONOUNCED DEAD Month <u>July</u> Day <u>29</u> Year <u>1968</u>		
7a. BIRTHPLACE (State or foreign country) <u>North Carolina</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <u>Montgomery</u> Md.		
10. CITY OR TOWN OF DEATH <u>Takoma Park</u>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Washington Sanatorium & Hosp.</u>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <u>Retired Bldg. Guard</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>Private Concern</u>		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <u>Maryland</u>		13b. COUNTY <u>Montgomery</u>		13c. CITY OR TOWN <u>Takoma Park</u>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <u>7309 Glenside Drive</u>
14. FATHER'S NAME First <u>Unknown</u> Middle <u> </u> Last <u> </u>				15. MOTHER'S MAIDEN NAME First <u>Unknown</u> Middle <u> </u> Last <u> </u>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> <u>Army WW1</u>		16b. SOCIAL SECURITY NO <u>579-09-7141</u>		17. INFORMANT <u>Harriet F. Register</u>		ADDRESS <u>7309 Glenside Drive Takoma Park, Md.</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute bronchopneumonia associated with</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a). <u>marked pulmonary emphysema and</u> stating the underlying cause lost <u>arteriosclerotic heart disease.</u> (b) <u> </u> (c) <u> </u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u> </u>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u> </u>								
19a. DATE OF OPERATION <u> </u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? <u> </u>				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <u> </u>		21b. TIME OF INJURY Month, Day, Year <u> </u> HOUR <u> </u> AM <u> </u> PM <u>19</u>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <u> </u>				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <u> </u>		21f. LOCATION Street or R.F.D. No <u> </u> City or Town <u> </u> County <u> </u> State <u> </u>		22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspect an <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion an death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		
ACTUAL SIGNATURE <u>Belden R. Reap</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED <u>July 29, 1968</u>		
EXAMINER'S NAME (Type) <u>BELDEN R. REAP, M.D.</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u> </u>		ADDRESS (Street, city, town, or county) <u> </u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>July 31, 1968</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Suitland, Maryland</u>				
24. FUNERAL DIRECTOR <u>Warner E. Humphrey, Inc.</u>		8434 ADDRESS <u>Georgia Ave. Silver Spring, Md.</u>		25a. REC'D BY REGISTRAR <u> </u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

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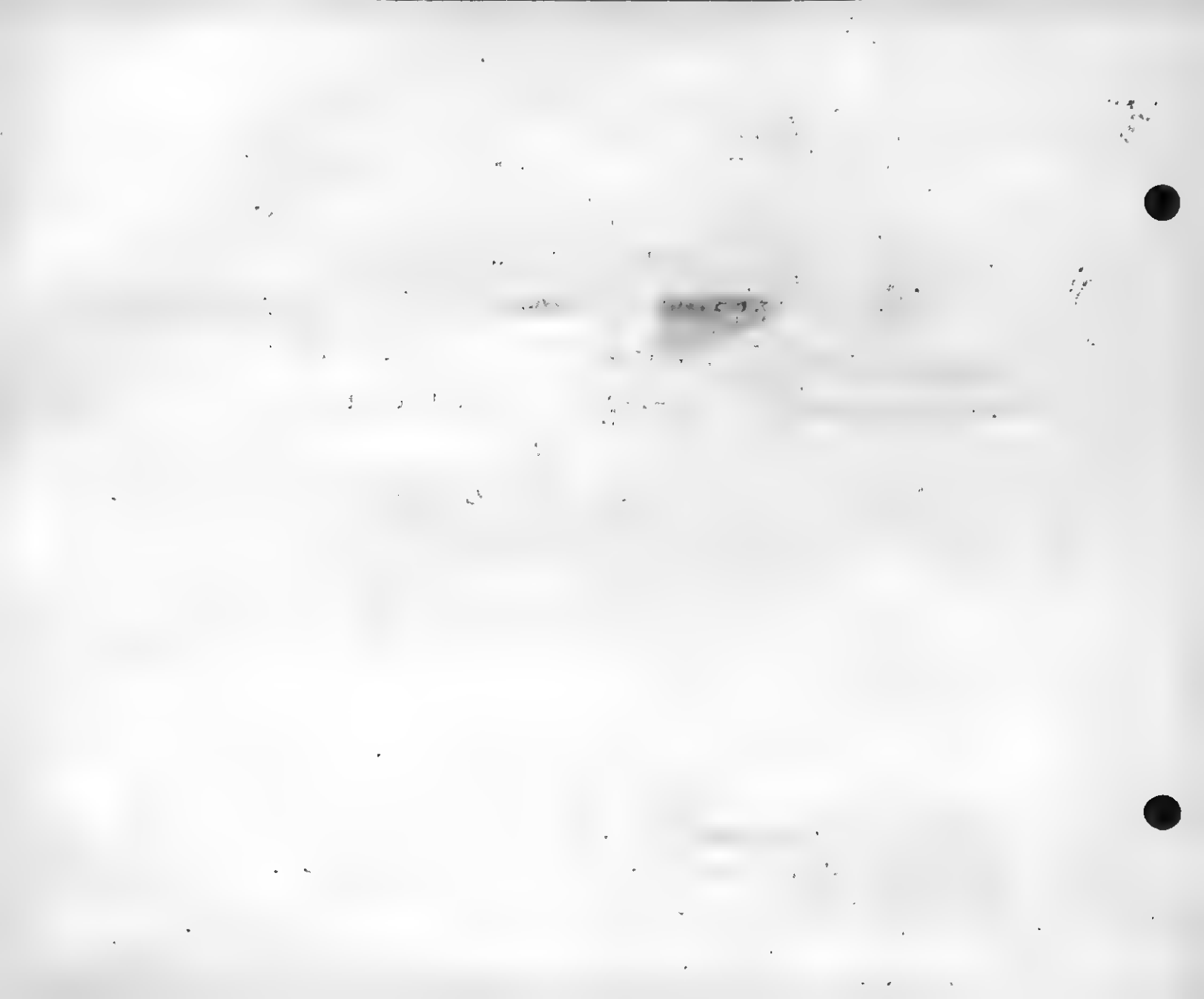
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. DECEASED NAME (Type or Print)			First CLEMENT		Middle JORDEN		Last REYNOLDS JR.		2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> Month Day Year 7 15 1968
3 SEX Male	4 RACE White	5 DATE OF BIRTH 8/3/39	6 AGE (in years last birthday) 28 YRS	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN	2c. DATE PRONOUNCED DEAD Month Day Year 7 15 1968		2b. HOUR (9) A M	
7a. BIRTHPLACE (State or foreign country) Washington D.C. USA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery		2d. HOUR 9 A M	
10. CITY OR TOWN OF DEATH Silver Spring, Md.			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Holy Cross			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) car dealer - Manager car sales		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission to STATE) Maryland			13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME First Middle Last Clement Jordan Reynolds Sr.			15. MOTHER'S MAIDEN NAME First Middle Last Julia Frances Jacobs			13e. STREET AND NUMBER 13203 Kara Lane Sil. Sprg.			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no			16b. SOCIAL SECURITY NO. (If yes give war or dates of service) yes		17. INFORMANT ADDRESS wife Alice 13203 Kara Lane Sil. Sprg. Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple Extreme Injuries</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. } (b) <u>with exsanguination</u> DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year 8:45 PM 7-15-1968		21c. HOW INJURY OCCURRED (Enter nature of accident in Part 2, item 18) Dropped, driver, slammed into rear of stationary vehicle				
21d. INJURY OCCURRED WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Street		21f. LOCATION Street or R.F.D. No. City or Town State Aspen Hill Rd. Silver Spring, Md.				
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Belden R. Reap			M.D. Belden R. Reap M.D.			22b. DATE SIGNED July 15, 1968			
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE July 18, 1968		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery		23d. LOCATION (City or Town) (County) (State) Silver Spring, Maryland		
24. FUNERAL DIRECTOR Jules Varner E. Pumphrey, Inc.			8434 Georgia Avenue Silver Spring, Md.		25a. REC'D BY REGISTRAR JUL 19 1968		25b. REGISTRAR'S SIGNATURE Charles Judge		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1 DECEASED-NAME (Type or print)			First Middle Last			2a DATE OF DEATH Month Day Year			2b HOUR		
Dorothy Rosa Richmond						July 18, 1968			7:5 P M		
3 SEX		4. RACE		5 DATE OF BIRTH			6 AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.
Female		White		September 10, 1898			69 YRS				
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH				
Maryland		America					Montgomery Md				
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b KIND OF BUSINESS OR INDUSTRY		
Takoma Park			Washington Sanitarium			none					
13a USUA. RES DENCE (Where deceased lived, if institution Res dence before admission) STATE			13b COUNTY			13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER	
Maryland			Pro Georges Hyattsville							7210 Wells Parkway--	
14. FATHER'S NAME First Middle Last			15 MOTHER'S MAIDEN NAME First Middle Last								
Thomas Richmond			Lillian Patrick								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)			16b SOCIAL SECURITY NO.			17. INFORMANT Address					
no			214-03-0541			Patinet's chart					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) Shock											
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost											
(b) Upper G-I Bleeding											4-5 days
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
CVA											
19a. DATE OF OPERATION		19b. CONDIT ON FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)							
21d INJURY OCCURRED White <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No.		City or Town		County		State	
22a I certify that (I) (this hospital) attended the deceased from July 18, 1967, to July 18, 1968, that (I) (we) last saw the deceased alive on July 18, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b SIGNATURE		DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c DATE SIGNED					
R. H. Sandstrom M.D.		M.D.				7-18-68					
22d PHYSICIAN'S NAME (Type)		22e ADDRESS									
R. H. Sandstrom M.D.		7701 Carroll Ave Takoma Park, Md									
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
Burial		July 23, 1968		Glenwood Cemetery		Washington D. C.					
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR DATE		25b. REGISTRAR'S SIGNATURE					
F. Gasch's Sons		Hyattsville, Md.		JUL 23 1968		Charles Judge					



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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers numbered 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH			2b. HOUR
SARATHA P ROBERTSON						July 16, 68			1 a M
3. SEX	4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		7. UNDER 1 YEAR	
F	W		4/14/03			65 YRS		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED		9. COUNTY OF DEATH	
Wash. D.C.			USA			NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Montgomery Co Md.	
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY
Rockville			Potomac Valley Nsg Home			Housewife			
13a. USUAL RESIDENCE (Where deceased lived, if institut on admission) STATE			13b. COUNTY	13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER	
Maryland			Montgomery	Chevy Chase		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		4819 Chevy Chase Blvd.	
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First Middle Last
George					Plitt	Elizabeth			Steidel
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO			17. INFORMANT			Address
NO			216-58-5859			Mr. George Robertson			4819 Chevy Chase Blvd.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardio Respiratory Failure									
DUE TO, OR AS A CONSEQUENCE OF (b) Brain Tumor									
DUE TO, OR AS A CONSEQUENCE OF (c)									
Conditions, if any, which gave rise to immediate cause (a), storing the underlying cause lost.									
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 1/2 mos									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
MEDICAL CERTIFICATION									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
4/29/68			Brain Tumor			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
			HOUR A.M. Month Day Year						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME FARM, STREET, FACTORY, OFFICE BUILDING, ETC)			21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from Dec 1, 1967, to July 16, 1968, that (I) (we) last saw the deceased alive on July 6, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death									
22b. SIGNATURE			22c. DATE SIGNED			22d. PHYSICIAN'S NAME (Type)			
Michel M. Healy MD			7/16/68			MICHEL M. HEALY, M.D.			
22e. ADDRESS			22f. ADDRESS						
			5411 W. Cedar Lane, Bethesda, Md.						
23a. BURIAL, CREMATION, or other disposition			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
Burial			7-13-68		Prospect Hill Cemetery		Washington D. C.		
24. FUNERAL DIRECTOR			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE			
Robert A Pumphrey Bethesda, Md.			JUL 19 1968			J Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or offending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) BERNARD — ROSSON			2a. DATE OF DEATH Month July Day 14 Year 1968			2b. HOUR 6:25 A M	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MARCH 21, 1908		6. AGE (In years last birthday) 60 YRS	
7a. BIRTHPLACE (State or foreign country) NEW YORK		7b. CITIZEN OF WHAT COUNTRY? UNITED STATES		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH MONTGOMERY Md	
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) HOLY CROSS		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) EXCAVATOR		12b. KIND OF BUSINESS OR INDUSTRY CONTRACTING	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MD.		13b. COUNTY MONTGOMERY S.S.		13c. CITY OR TOWN YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME First SAMUEL Middle ROSSON Last ROSSON		15. MOTHER'S MAIDEN NAME First FRIEDA Middle ? Last ?					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) NO		16b. SOCIAL SECURITY NO. 578-28-1041		17. INFORMANT MILDRED B. ROSSON		Address JAME AS 13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Bilateral Bronchopneumonia DUE TO, OR AS A CONSEQUENCE OF (b) Cancer of Lung DUE TO, OR AS A CONSEQUENCE OF (c) Cancer of Lung Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days 9 months
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 1.2							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from June 1, 1968 to July 14, 1968 , that (I) (we) last saw the deceased alive on July 13, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death							
22b. SIGNATURE BLAINE H. ETG		DEGREE MD		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 7/14/1968	
22d. PHYSICIAN'S NAME (Type) BLAINE H. ETG		22e. ADDRESS 9801 New Market Road, Silver Spring, MD					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 7-15-68		23c. NAME OF CEMETERY OR CREMATORY NAT'L MEMORIAL PARK		23d. LOCATION (City or Town) (County) (State) FAIRFAX CHURCH VA	
24. FUNERAL DIRECTOR Frederick Funeral Home		ADDRESS 4217 E. W. AVE		25a. REC'D BY REGISTRAR JUL 17 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	



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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH												
1 DECEASED-NAME (Type or print)			First <u>Robert</u> Middle <u>C.</u> Last <u>Roy</u>			2a DATE OF DEATH Month <u>7</u> Day <u>6</u> Year <u>1968</u>			2b HOUR <u>7:05</u> M			
3. SEX <u>Male</u>		4. RACE <u>Caucasian</u>		5. DATE OF BIRTH <u>9-17-76</u>			6 AGE (In years last birthday) <u>91</u> YRS.		IF UNDER 1 YEAR MONTHS <u>9</u> DAYS <u>19</u>		IF UNDER 24 HRS. HOURS <u></u> MIN <u></u>	
7a BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		7b CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <u>Montgomery</u> Md						
10. CITY OR TOWN OF DEATH <u>Cherry Chase</u>			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Bethesda - Silver Spring</u>			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <u>Dentist</u>			12b. KIND OF BUSINESS OR INDUSTRY <u>Dentist</u>			
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <u>Wash., D.C.</u>			13b COUNTY <u>D.C.</u>		13c CITY OR TOWN <u>Wash. D.C.</u>		13d INSIDE CITY LIMITS? <u>YES</u> <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER <u>3125 Birch St., N.W.</u>			
14 FATHER'S NAME First <u>Robert J.</u> Middle <u></u> Last <u>Roy</u>			15 MOTHER'S MAIDEN NAME First <u></u> Middle <u></u> Last <u>Unknown</u>									
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <u></u>			16b SOCIAL SECURITY NO. <u></u>			17 INFORMANT <u>Attent's Chart</u>			Address <u>Bethesda Silver Spring</u> <u>Nursing Home, Ch. Ch. Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))												
PART 1 DEATH WAS CAUSED BY.												
IMMEDIATE CAUSE (a) <u>Myocardial failure</u>												
DUE TO, OR AS A CONSEQUENCE OF												
(b) <u>ANOXIA</u>												
DUE TO, OR AS A CONSEQUENCE OF												
(c) <u>Gastrointestinal hemorrhage</u>												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)												
<u>577x None</u>												
19a DATE OF OPERATION <u>None</u>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>None</u>			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b TIME OF INJURY HOUR A.M. Month Day Year P.M. <u>19</u>			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.			21f LOCATION Street or R.F.D. No. City or Town County State						
22a I certify that (I) (this hospital) attended the deceased from <u>1965</u> , 19 <u>65</u> , to <u>present</u> , that (I) (we) last saw the deceased alive on <u>7/1</u> 19 <u>68</u> , and that (my) (our) apian death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b SIGNATURE <u>John B. Umhau MD</u>			ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED <u>7/6/68</u>						
22d PHYSICIAN'S NAME (Type) <u>JOHN B. Umhau</u>			22e. ADDRESS <u>8805 Conn. Ave. Ch. Ch. Md.</u>									
23a BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>			23b DATE <u>7/10/1968</u>			23c NAME OF CEMETERY OR CREMATORY <u>HOMEWOOD CEMETERY</u>			23d LOCATION (City or Town) (County) (State) <u>PITTSBURGH, PENNA.</u>			
24 FUNERAL DIRECTOR <u>Myerson's Funeral Home</u>			ADDRESS <u>1300 N. 5th St. W., Wash. D.C.</u>			25a REC'D BY REGISTRAR <u>JUL - 9 1968</u>			25b REGISTRAR'S SIGNATURE <u>John Charles Judge</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A13.4
30M REV 3/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) William A. Sadden			2a. DATE OF DEATH July Month 28 Day Year 68			7b. HOUR 1:45 P.M.	
3. SEX Male		4. RACE White		5. DATE OF BIRTH 09-27-1881		6. AGE (in years last birthday) 86 YRS.	
7a. BIRTHPLACE (State or foreign country) Penton, Mass.		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.	
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Colonial Villa 12325 N. Hamp. Ave., Sil. sp.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if ret. red.) Govt. Employee		12b. KIND OF BUSINESS OR INDUSTRY U.S. Gov.	
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE Maryland		13b. COUNTY Prince Geo.		13c. CITY OR TOWN Adelphi		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 8203-16th Ave.,		14. FATHER'S NAME First Middle Last Charles Sadden		15. MOTHER'S MAIDEN NAME First Middle Last Lydia			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Unknown		16b. SOCIAL SECURITY NO. 215-48-1981-T		17. INFORMANT Nursing Home Records, 12325 N. Hamp. Ave., SS.		Address	
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c))							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> 4129 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Cardio-vascular disease</u> several years DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 7221							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from April, 1968, to July 28, 1968, that (I) (we) lost the deceased alive on July 27, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE E. N. C. MAGI				DEGREE M.D.		22c. DATE SIGNED 7-28-68	
22d. PHYSICIAN'S NAME (Type) E. N. C. MAGI				22e. ADDRESS 831 University Blvd. E., Sil. sp., Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE July 30-1968		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery, Suitland P. Res. Md.		23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR Charles Judge		ADDRESS 25+ Carroll ST. 110		25a. REC'D BY REGISTRAR DATE JUL 30 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	



Dr Beldon Reap, Medical Examiner-Callie
Concerning this death and be authorized to sign
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and return them to the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

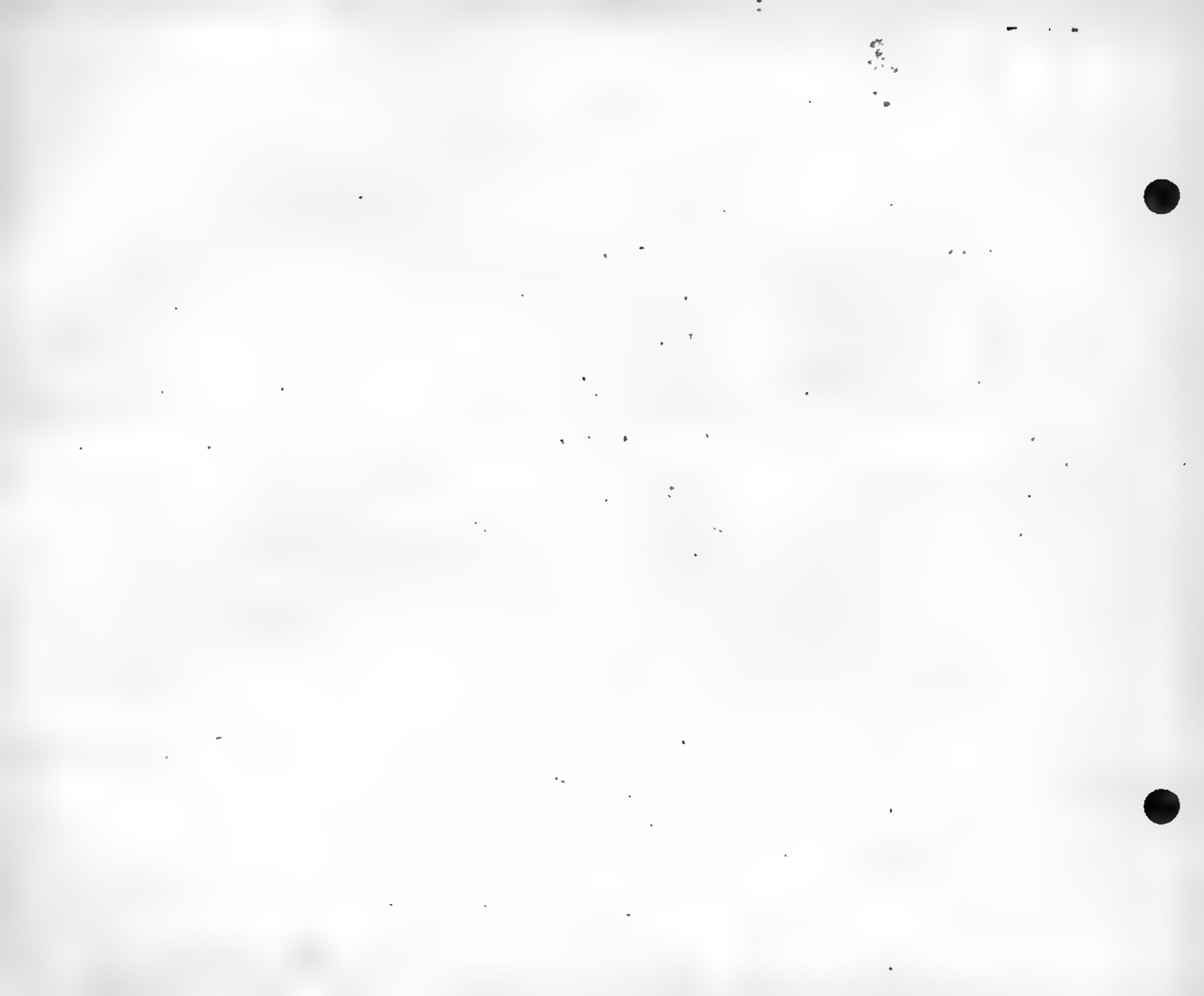
1. DECEASED-NAME				2a. DATE OF DEATH		2b. HOUR	
First Middle Last				Month Day Year		HOURS MIN.	
Florence Vernie Sager				July 22 1968		3:12 P.M.	
3 SEX		4 RACE		5. DATE OF BIRTH		6. AGE (in years last birthday)	
Female		White		8-14-90		77 YRS.	
7a BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH	
Virginia		USA		Montgomery		Md.	
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
TAKOMA PARK		WASH. San + Hosp.		Sales Person		Real Estate	
13a USUA. RES DENCE (Where deceased lived, if institution Res dence before admission) STATE		13b. COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIM TSP	
MD		MONTGOMERY		Silver Sp		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME First Middle Last		15. MOTHER'S MAIDEN NAME First Middle Last		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service)		16b SOCIAL SECURITY NO.	
Samuel B Hepner		Minnie - Dellinger		no		577-34-1710	
17 INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
Shelma S. Davis 9310 Baltimore Dr. Silver Spring, Md.		PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Hemorrhage, Massive		2.4 hrs			
		DUE TO OR AS A CONSEQUENCE OF (b) Cerebral Arterio-sclerosis		Undetermined			
		DUE TO OR AS A CONSEQUENCE OF (c) Arterial Hypertension		Undetermined			
		PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
		Secondary to Generalized Arterio-sclerosis					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from July 30, 1967 to July 22, 1968; that (I) (we) last saw the deceased alive on July 3, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE		22c. DATE SIGNED			
		George L. Ball		July 22, 1968			
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS		22f. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
George L. Ball		Silver Spring, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)	
Burial		July 25, 1968		Cedar Hill Cemetery		Suitland, Maryland	
24. GENERAL DIRECTOR		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
C. Glen Carter 434 Georgia Ave. Warner E. Pumphrey, Inc. Silver Spring, Md.		DATE JUL 29 1968		J. Charles Judge			



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers ~~pages 1 and 2~~ should be filed with the State Dept. of Health prior to burial, cremation or removal, and in any event, within 72 hours after death.

Received by Dr. Reed for Dr. Curry to sign - R.C.

D49



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH			2b. HOUR
SATENIG BAGDOIAN SARKISIAN						July 29 1968			1:30 PM
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR	
Female		White		9/6/1958		72 YRS.		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Armenia		USA				Montgomery Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY
Bethesda			Suburban			Retired			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN	13d. INSIDE CITY - IN 1ST? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Md			Mont		Rockville			14308 Blodgett St.	
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First Middle Last
HAGOP						MARY			ESKENIAN
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.		17. INFORMANT		Address		
No			033-09-0795		VAHA SARKISIAN		89 Forest St, Methuen, MASS		
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b) and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial infarction, recent and remote									
DUE TO, OR AS A CONSEQUENCE OF (b) Coronary arteriosclerosis with thrombosis									
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
Leukemia, acute DUE TO AGNOGENIC MYELOID METAPLASIA & MYELOFIBROSIS									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
		HOUR A.M. Month Day Year P.M. 19							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from May, 1968, to July 29, 1968, that (I) (we) last saw the deceased alive on 29 July 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Eugene P. Libre M.D.					22c. DATE SIGNED		30 July 1968		
22d. PHYSICIAN'S NAME (Type) EUGENE P. LIBRE					22e. ADDRESS 10400 Conn. Ave. Kensington Md. 20795				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		2 Aug. 1968		Bellevue Cemetery		Lawrence Mass			
24. FUNERAL DIRECTOR					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
RINALDI FUNERAL HOME 7406 GEORGIA AVE., N.W.					JUL 31 1968		Charles Judge		

MEDICAL CERTIFICATION



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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) Kenneth		First S	Middle S	Last Savage	2a. DATE OF DEATH Month 7 Day 9 Year 68		2b. HOUR 2:57 M
3 SEX MALE	4. RACE White	5. DATE OF BIRTH 7-19-33		6 AGE (in years last birthday) 34 YRS	IF UNDER 1 YEAR MONTHS 0 DAYS 0	IF UNDER 1 YEAR HOURS 0 MIN 0	
7a. BIRTHPLACE (State or foreign country) WASH DC	7b. CITIZEN OF WHAT COUNTRY? U.S.	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Montgomery Md			
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Ably Cross		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) FARMER		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) STATE Md.		13b. COUNTY Boys	13c. CITY OR TOWN Boys	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER Rt. # 1 P.O. Box 29		
14. FATHER'S NAME Harry Savage		First S	Middle S	Last Savage	15. MOTHER'S MAIDEN NAME First Osi Poole Middle S Last Poole		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 217-30-2485		17. INFORMANT Address Greta M. Savage- Rt. # 1, Boyds, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Constrictive Hemorrhage 5110 DUE TO, OR AS A CONSEQUENCE OF Multiple Superficial gastric ulcerations DUE TO, OR AS A CONSEQUENCE OF chronic Alcoholism Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last							APPROXIMATE INTERVAL, BETWEEN ONSET AND DEATH 36 hrs
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) ALCOHOLIC CIRRHOSIS							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (if either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from approx 19:00 to July 9, 1968 , that (I) (we) lost the deceased alive on 7-9 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death							
22b. SIGNATURE Stanley M. Silverberg M.D.				22c. DATE SIGNED 7-9-68		22d. PHYSICIAN'S NAME (Type) STANLEY M. SILVERBERG M.D.	
22e. ADDRESS 5201 CONN AVE NW WASH DC							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 7/12/68		23c. NAME OF CEMETERY OR CREMATORY Monocacy Cemetery		23d. LOCATION (City or Town) (County) (State) Beallsville, Md.	
24. FUNERAL DIRECTOR Tyson Wheeler Funeral Home-1331 Rockville Pike Rockville, Md.				25a. REC'D BY REGISTRAR JUL 11 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	



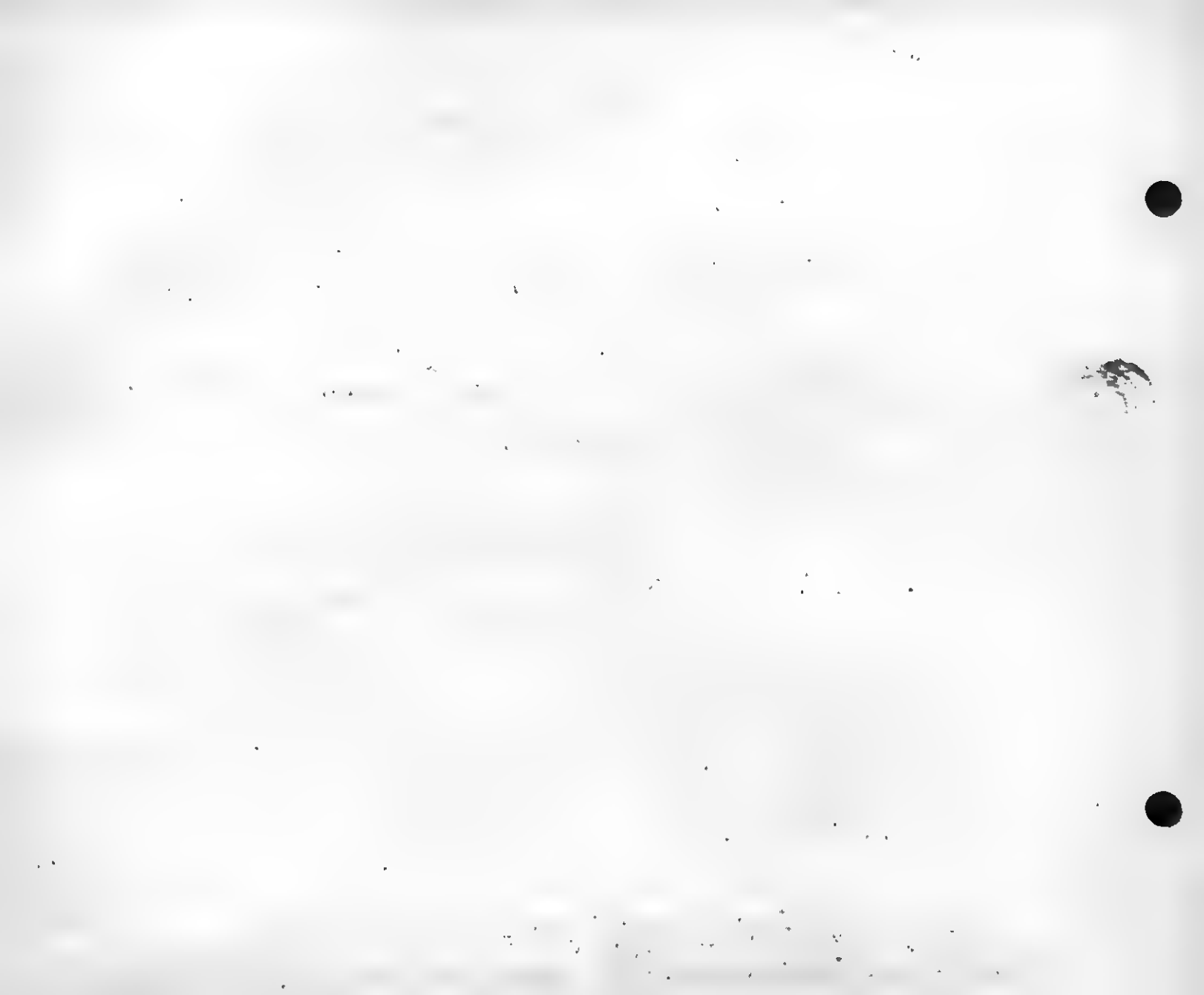
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print) FRANK SAMUEL SCALZO			2a DATE OF DEATH Month 7 Day 18 Year 68			2b HOUR 6:45 P.M.
3 SEX Male	4. RACE White	5 DATE OF BIRTH 5-15-26		6 AGE (in years lost birthday) 82 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	IF UNDER 24 HRS HOURS MIN
7a BIRTHPLACE (State or foreign country) Italy	7b. CITIZEN OF WHAT COUNTRY? America	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH MONTGOMERY Md.		
10. CITY OR TOWN OF DEATH Takoma Park, Md.		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Wash. San. Hospital		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Ret. a painting		12b KIND OF BUSINESS OR INDUSTRY Ret.
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE OHIO		13b COUNTY Summitt	13c CITY OR TOWN AKRON	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET AND NUMBER 976 CONCORD AVE.	
14 FATHER'S NAME First Middle Last Salvador Scalzo			15. MOTHER'S MAIDEN NAME First Middle Last Angelita			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO		17 INFORMANT Address RALPH R. SCALZO, 10117 BRUNSWICK AVE SE.		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary embolism 450 X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 465 X (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH < 24 HRS.
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Arteriosclerotic heart disease						
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
21d INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State		
22a. I certify that (I) (this hospital) attended the deceased from May 1, 1968 , to July 18, 1968 , that (I) (we) last saw the deceased alive on July 18, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b SIGNATURE Benne H. Boudan				DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 7/19/68
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS 10820 Georgia Ave. Silver Spring Md		
23a BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE July 23, 1968		23c. NAME OF CEMETERY OR CREMATORY Holy Cross Cemetery		23d. LOCATION (City or Town) (County) (State) Akron Ohio
24. FUNERAL DIRECTOR Robert Walters		25a. REC'D BY REGISTRAR 254 Carroll St. 2nd Fl. Wash, D.C. 20012		25b. REGISTRAR'S SIGNATURE Charles Judge		DATE JUL 22 1968



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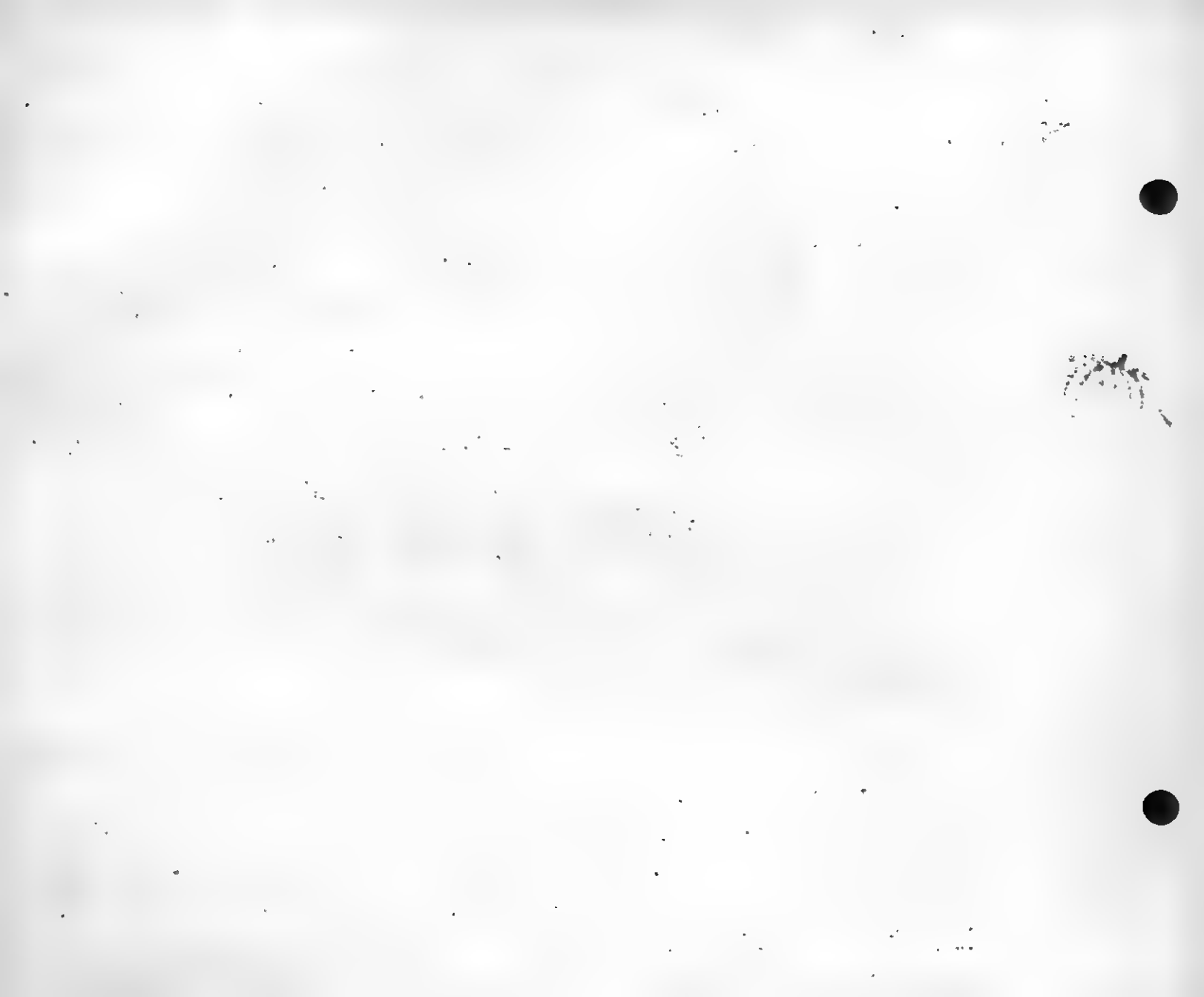
1 DECEASED NAME (Type or print)				First		Middle		Last		2a. DATE OF DEATH			2b. HOUR	
EUGENE JOHN Schlatter										Month 7 Day 5 Year 68			10:15 PM	
3 SEX		4 RACE		5 DATE OF BIRTH			6 AGE (In years last birthday)			IF UNDER 1 YEAR		IF UNDER 24 HRS.		
Male		White		1-20-08			60 YRS.			MONTHS DAYS		HOURS MIN.		
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH							
Pa.		Amer.					Montgomery County Md							
10 CITY OR TOWN OF DEATH				11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a USUAL OCCUPATION (Kind of work done during most of work ing life, even if retired)				12b KIND OF BUSINESS OR INDUSTRY		
TAKOMA PARK				Washington Sanatorium-Hosp. Retired: Geological Survey								Civil Eng.		
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE				13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER				
MD.				Montgomery County		Silver Spring				9504 BRACE DR. 3020901				
14 FATHER'S NAME			First			Middle			Last			15. MOTHER'S MAIDEN NAME First Middle Last		
Eugene			Schlatter						Bertha			Vogelbacher		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown				16b SOCIAL SECURITY NO.				17 INFORMANT				Address		
no				710				Marlene H Schlatter				34 Bruce Dr. Silver Spring, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)													APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:														
IMMEDIATE CAUSE (a) <u>Pneumonia</u>													1 wk.	
DUE TO, OR AS A CONSEQUENCE OF														
(b) <u>diffuse pulmonary interstitial</u>													10 yrs	
DUE TO, OR AS A CONSEQUENCE OF														
(c) <u>fibrosis</u>														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)														
19a DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M.			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State								
22a. I certify that (I) (this hospital) attended the deceased from Sept 16, 1966, to July 5, 1968, that (I) (we) lost saw the deceased alive on July 5, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														
22b SIGNATURE			22c. DATE SIGNED			22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS			22f. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		
Myron L. Lenkin			7/6/68			Myron L. Lenkin			2309 Shorefield Rd, Wheaton, Md.					
23a BURIAL, CREMATION, REMOVAL (Specify)			23b DATE			23c. NAME OF CEMETERY OR CREMATORY			23d LOCATION (City or Town) (County) (State)					
Burial			July 9, 1968			St. Lincoln Cemetery			Prince George Co., Md.					
24 FUNERAL DIRECTOR			25a. REC'D BY REGISTRAR			25b REGISTRAR'S SIGNATURE			25c. DATE					
Charles E. Purnskey, Inc. Silver Spring, Md.			JUL 11 1968			J. Charles Young								



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR
Infant Girl Seaquist						7 18 68			5: A. M.
3 SEX	4. RACE		5 DATE OF BIRTH			6 AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS. HOURS MIN.
Female	White		7/16/19			YRS.		2	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Md.		U.S.A.				Montgomery			
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY	
Rockville			Suburban Hospital						
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b COUNTY			13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
Md.			Montgomery			Rockville		YES	
14. FATHER'S NAME			15 MOTHER'S MAIDEN NAME			13e STREET AND NUMBER			
First Middle Last			First Middle Last			443-Blossom Middle			
Michael E. Seaquist			Dixie E. ?			Rockville, Md.			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, (no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT Address			
No			None			Michael E. Seaquist Same as 14b			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pulmonary Edema									40 hrs.
DUE TO, OR AS A CONSEQUENCE OF (b) Huge Interventricular Septal Defect									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first (c) Multiple Congenital Anomalies									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Frank Mate, Jr. M.D. DEGREE						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 7/19/68	
22d. PHYSICIAN'S NAME (Type) Frank Mate, Jr.						22e. ADDRESS Edmondston Ave., Rockville, Md.			
23a BURIAL, CREMATION, REMOVAL (Specify)			23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
Cremation			7/19/68		Cedar Hill Cemetery		Baltimore Md.		
24a. FUNERAL DIRECTOR Charles E. Baker 1377 Rockville Pike						25a. REC'D BY REGISTRAR DATE JUL 22 1968		25b. REGISTRAR'S SIGNATURE J. Charles Judge	
Funeral Home Rockville, Maryland									



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health or to burial, cremation, or removal, and in any event, within 72 hours after death.

10380

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

10380

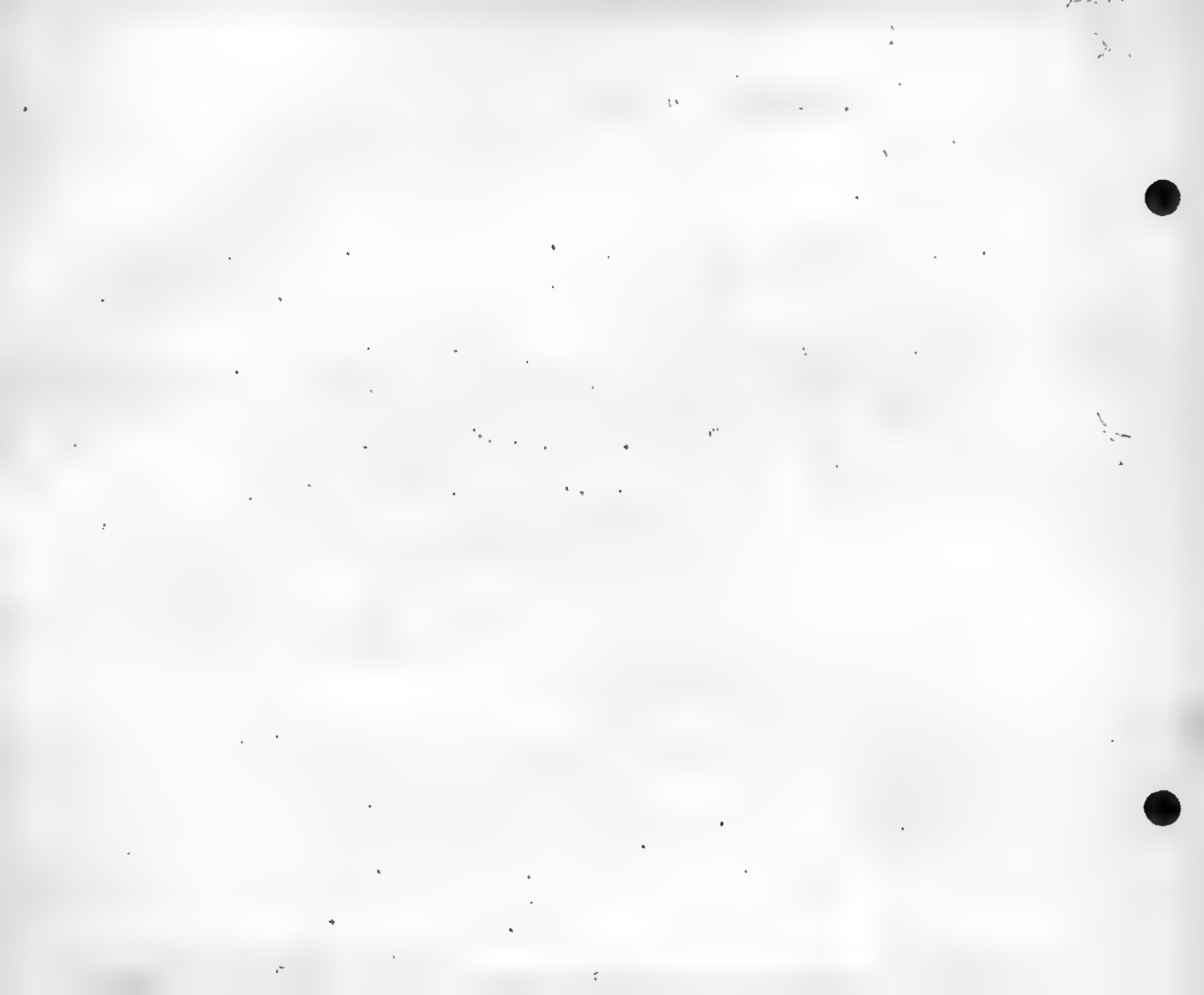
1. DECEASED-NAME (Type or print) Vicki H SEEKARD			2a. DATE OF DEATH Month Day Year 7 22 68			2b. HOUR 7:30 PM					
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH 12-11-94		6. AGE (In years last birthday) 73 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.					
10. CITY OR TOWN OF DEATH Baltimore			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Frederick Douglass Home			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) School Teacher			12b. KIND OF BUSINESS OR INDUSTRY D.C. Schools		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland			13b. COUNTY Washington		13c. CITY OR TOWN DC		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 3829 T. Street N.W.		
14. FATHER'S NAME First Middle Last Johnson B. Holmes			15. MOTHER'S MAIDEN NAME First Middle Last Unobtainable								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no			16b. SOCIAL SECURITY NO. 578-60-8632		17. INFORMANT Dr. Page Seckford			Address Charleston, W. Va.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Artery</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ASHD</u> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>4 years</u> <u>3 yrs</u>											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Generalized Arteriosclerosis</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <u>1/14, 1968</u> , to <u>7/22, 1968</u> , that (I) (we) last saw the deceased alive on <u>7/22, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Robert C. Macon</u>					DEGREE ATTENDING PHYS.		MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>7/22/68</u>		
22d. PHYSICIAN'S NAME (Type) Robert C. Macon					22e. ADDRESS 809 Veirs Mill Rd. Rockville Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE 7/26/68		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery			23d. LOCATION (City or Town) (County) (State) Prince Georges Co. Md.				
24. FUNERAL DIRECTOR The S. H. Hines Co. 2901 14th St. N. W. Washington, DC					25a. REC'D BY REGISTRAR JUL 26 1968		25b. REGISTRAR'S SIGNATURE Charles Judge				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED NAME (Type or print) BESSIE ANNA SELBIN						2a. DATE OF DEATH Month 7 Day 15 Year 68		2b. HOUR 12:30 P.M.			
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MAR. 15, 1898		6. AGE (In years lost birthday) 70 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) MD		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH MONTGOMERY Md					
10. CITY OR TOWN OF DEATH TAKOMA PARK		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) WASH. San. & Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) SEAMSTRESS		12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE FLORIDA 13b. COUNTY DADE				13c. CITY OR TOWN MIAMI		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 329-N.W. 48th St.			
14. FATHER'S NAME First Middle Last MORRIS GOLDBERG				15. MOTHER'S MAIDEN NAME First Middle Last FRIEDA WEBMAN							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO		16b. SOCIAL SECURITY NO 152-12-7746		17. INFORMANT DAUGHTER Address MRS. ESTELLE COHEN 10612-EDGEWOOD AV. SILVER SPRING, MD							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pneumonia DUE TO, OR AS A CONSEQUENCE OF (b) Intractable Congestive Heart Failure DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerosis										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 14 days 2 months 15 years	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) None											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from 5/11 , 19 68 , to 7/15 , 19 68 , that (I) (we) last saw the deceased alive on 7/14 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Samuel Dessoff, MD DEGREE <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>						22c. DATE SIGNED 7/15/68					
22d. PHYSICIAN'S NAME (Type) SAMUEL DESSOFF, MD						22e. ADDRESS 1302 18th St. N.W. - Washington, D.C.					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 7-16-68		23c. NAME OF CEMETERY OR CREMATORY MT. LEBANON CEM		23d. LOCATION (City or Town) (County) (State) 1+YATTSVILLE MD					
24. FUNERAL DIRECTOR BERNARD DANCANSKY & SONS				ADDRESS 3501-14th St. N.W. Washington, D.C.		25a. REC'D BY REGISTRAR JUL 18 1968		25b. REGISTRAR'S SIGNATURE J. Charles Judge			



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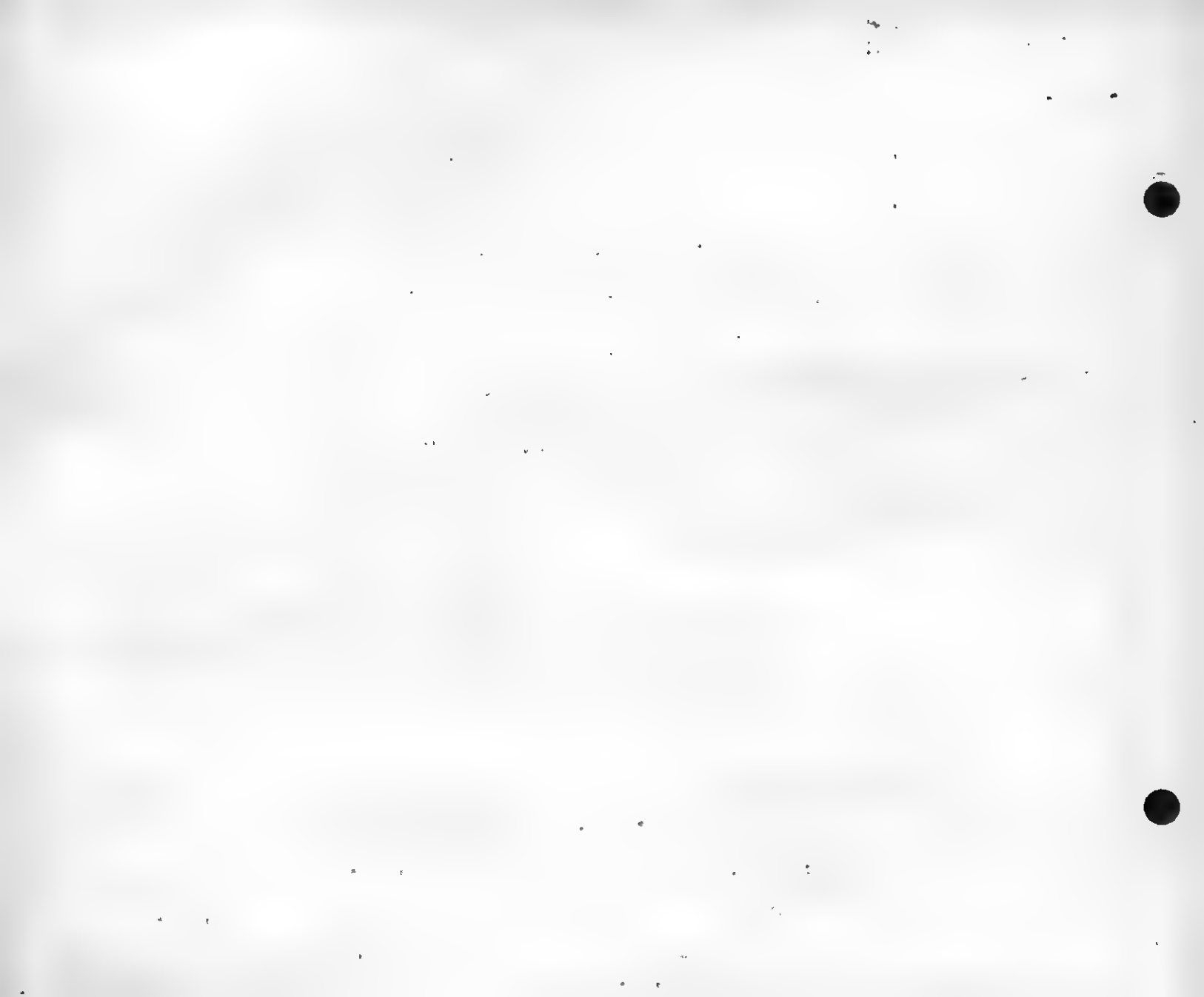
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VR A15
30M REV. 1-58

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First Middle Last — — SELIGA			2a. DATE OF DEATH Month Day Year JULY 22 1968			2b. HOUR 10 ⁵⁸ A M	
3 SEX FEMALE		4 RACE WHITE		5 DATE OF BIRTH JULY 22, 1968		6 AGE (In years last birthday) — YRS — MONTHS — DAYS	
7a BIRTHPLACE (State or foreign country) MARYLAND		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH MONTGOMERY Md	
10 CITY OR TOWN OF DEATH SILVER		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) HOLY CROSS HOSPITAL		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE MARYLAND		13b COUNTY MONTGOMERY		13c CITY OR TOWN WHEATON		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e STREET AND NUMBER 3101 PARKER AVE.		14 FATHER'S NAME First Middle Last REGIS Ronald SELIGA		15. MOTHER'S MAIDEN NAME First Middle Last JUDITH Ann HAMES		16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) NO	
16b. SOCIAL SECURITY NO. —		17 INFORMANT FATHER		Address 3101 PARKER AVE. MD		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple Congestive Coronaries 7-77 DUE TO, OR AS A CONSEQUENCE OF (b) Pericarditis DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 7592							
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work at work		21e PLACE OF INJURY (At home, farm, street, factory) OFFICE BUILDING, ETC		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death							
22b SIGNATURE M. Tabb		DEGREE M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22d. PHYSICIAN'S NAME (Type) M. Tabb		22e. ADDRESS Wheaton, Md.		22c. DATE SIGNED 7-22-68			
23a BURIAL, CREMATION, or other final disposition of body BURIAL		23b. DATE 7/25/68		23c NAME OF CEMETERY OR CREMATORY Gate of Heaven		23d LOCATION (City or Town) (County) (State) Silver Spring, Md.	
24 FUNERAL DIRECTOR Tyson Wheeler Funeral Home-1331 Rockville Pike Rockville, Md.				25a REC'D BY REGISTRAR DATE JUL 30 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	

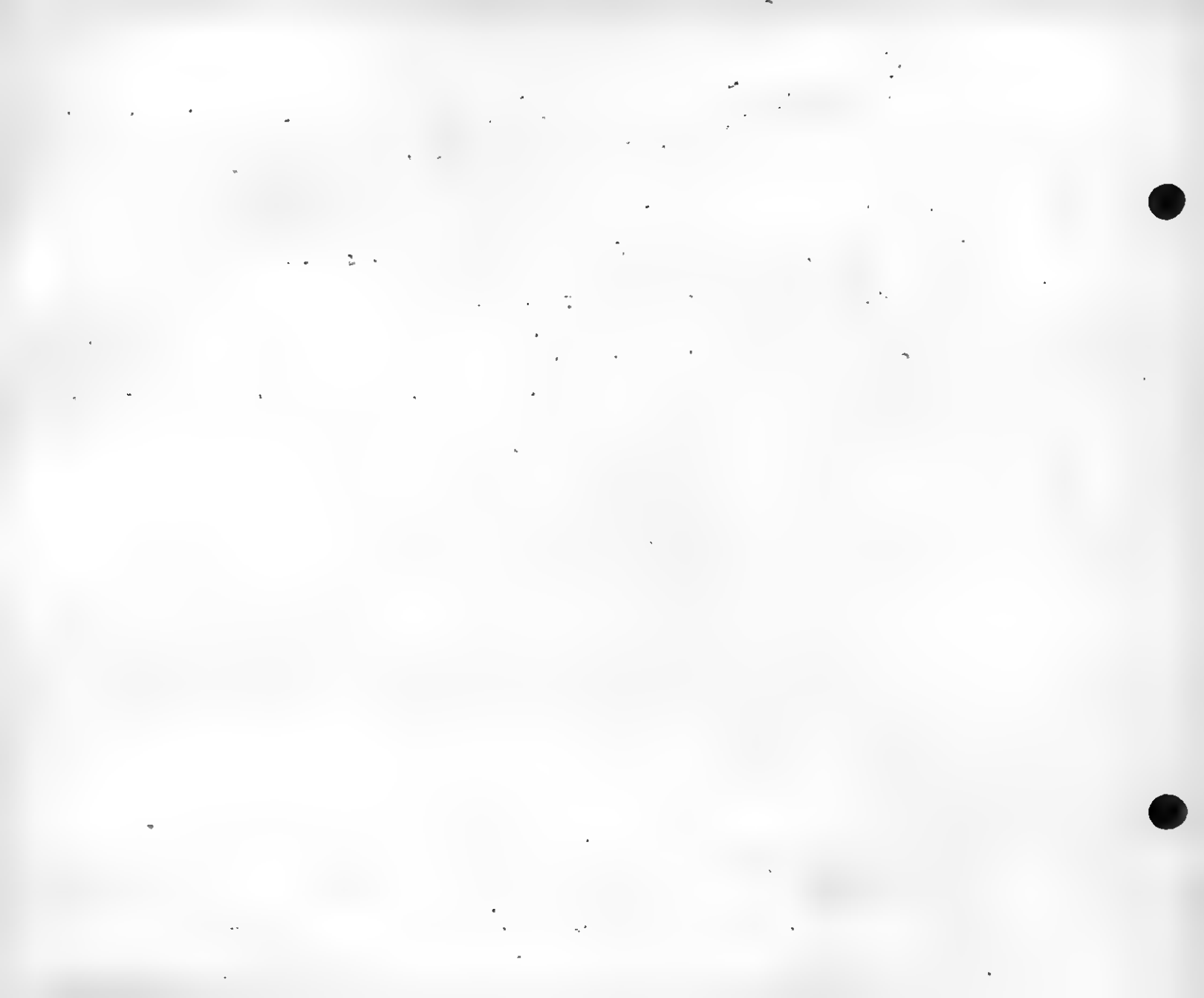


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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) Bertha F. Shack			2a DATE OF DEATH Month July Day 22 Year 68			2b HOUR 8:07 P.M.			
3 SEX Female		4 RACE WHITE		5. DATE OF BIRTH 2/12/95		6 AGE (In years last birthday) 73 YRS		IF UNDER 1 YEAR MONTHS 73 DAYS 73 HOURS 73 MIN.	
7a BIRTHPLACE (State or foreign country) RUSSIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.			
10 CITY OR TOWN OF DEATH Silver Spring		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Holy Cross Hosp.		12a USUAL OCCUPATION (Kind of work done during most of working life even if retired) HOUSEWIFE		12b KIND OF BUSINESS OR INDUSTRY -			
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MD.		13b COUNTY MONTGOMERY		13c CITY OR TOWN S.S.P.G.		13d INSIDE CITY (Y/N) YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 1001 SPRING ST.	
14. FATHER'S NAME First SAMUEL Middle - Last FREEDMAN			15 MOTHER'S MAIDEN NAME First ANNA Middle - Last GLASS						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO (If yes give year or dates of service)		16b. SOCIAL SECURITY NO. UNKNOWN		17 INFORMANT MILTON KAPLAN		Address 1600 SEADS AVE. VA.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 4129 Shock & Cardiovascular Collapse DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last 4129 (b) U.I. bleeding DUE TO, OR AS A CONSEQUENCE OF (c) Stress ulcer								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Basilar artery aneurysm & multiple brain stem infarcts.									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 6-29 , 19 68 , to 7-18 , 19 68 , that (I) (we) last saw the deceased alive on 7-18 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Bernard A. Heckman, M.D. DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22c. DATE SIGNED 7-22-68					
22d. PHYSICIAN'S NAME (Type) BERNARD A. HECKMAN				22e. ADDRESS 8107 EASTERN AVE SIL. SP. MD.					
23a. BURIAL CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 7-24-68		23c. NAME OF CEMETERY OR CREMATORY NATIONAL MEM PARK		23d. LOCATION (City or Town) (County) (State) FALLS CHURCH VA.			
24. FUNERAL DIRECTOR Goldsberg Funeral Home		ADDRESS 4217-9th Ave		25a. REC'D BY REGISTRAR JUL 29 1968		25b. REGISTRAR'S SIGNATURE J. Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
CERTIFICATE OF DEATH												
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR M			
Nelson			Shaenfeld			July 24 68			6:50 P.			
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (in years lost birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
MALE		WHITE		5/2/08			60 YRS.					
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Md.						
Penn.		U.S.A.				Montgomery						
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY		
Bethesda				Suburban				Merchant		Rayson Bus		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before death)				13b. CITY OR TOWN		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER				
Bethesda				Montgomery		Cheltenham		208 Barclay Circle				
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S M.A.D.E.N. NAME			First	Middle	Last	
Joseph			Shaenfeld			Sonya			Kleymann			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)				16b. SOCIAL SECURITY NO		17. INFORMANT		Address				
No				unknown		Mary Shaenfeld		Same as above				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial Infarction acute											4 days	
4109 DUE TO, OR AS A CONSEQUENCE OF												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												
DUE TO, OR AS A CONSEQUENCE OF												
(c)												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, not by medical exam'n)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No.			City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from Jul 21, 1968, to Jul 24, 1968, that (I) (we) last saw the deceased alive on Jul 24, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (yes) (did) (did not) view the body after death.												
22b. SIGNATURE Isidore Shulman M.D.						ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>			22c. DATE SIGNED 7-24-68			
22d. PHYSICIAN'S NAME (Type) Isidore Shulman						22e. ADDRESS 915- 19th St N.W. D.C.						
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)				
Burial			7/26/68		KING DAVID			CORNWELL HILLS ROCKS PA.				
24. FUNERAL DIRECTOR Goldberg Funeral Home						ADDRESS 4217 9th St NW Wash., D.C.			25a. REC'D BY REGISTRAR AUG 19 1968		25b. REGISTRAR'S SIGNATURE John D. Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1 DECEASED NAME (Type or print)			First Middle Last			2a DATE OF DEATH Month Day Year		2b HOUR P		
Melford			Sanford			Shrieves		July 8 1968 9:15 M		
3. SEX		4. RACE		5 DATE OF BIRTH		6 AGE (in years lost birthday)		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
Male		Negro		10 January 1916		52 YRS.				
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH				
Virginia		USA				Montgomery Md.				
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of work life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY		
Bethesda			The Clinical Center			Construction		Construction		
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER	
Delaware			Sussex		Frankford		YES		Route 2, Box 311	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME							
First Middle Last			First Middle Last							
Jacob			Shrieves			Lucie Warner				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b SOCIAL SECURITY NO.		17 INFORMANT The Medical Record Address					
No			224-14-8678		The Clinical Center, NIH, Bethesda, Md. 20014					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gastrointestinal Bleeding</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Uremia</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Chronic Myelogenous Leukemia</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days 4 weeks 34 Months	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that XX (this hospital) attended the deceased from <u>24 June</u> , 19 <u>68</u> , to <u>8 July</u> , 19 <u>68</u> , that XX (we) last saw the deceased alive on <u>8 July</u> , 19 <u>68</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, XX (we) (did) not view the body after death.										
22b. SIGNATURE <u>Peter G. Burk MD</u> DEGREE					ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c DATE SIGNED 8 July 1968			
22d. PHYSICIAN'S NAME (Type) <u>Peter G. Burk, MD.</u>					22e ADDRESS <u>The Clinical Center, National Institutes of Health, Bethesda, Md. 20014</u>					
23a BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Burial		July 12, 1968		St. John's		Millsboro Sussex Del.				
24. FUNERAL DIRECTOR <u>A. Douglas Nelson, Frankford, Del.</u> ADDRESS					25a. REC'D BY REGISTRAR <u>JUL 16 1968</u> DATE		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>			

MEDICAL CERTIFICATION



Released to funeral home per Dr. Resp. 7/23/68.

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form P-10. Page 5 may be retained for your files.

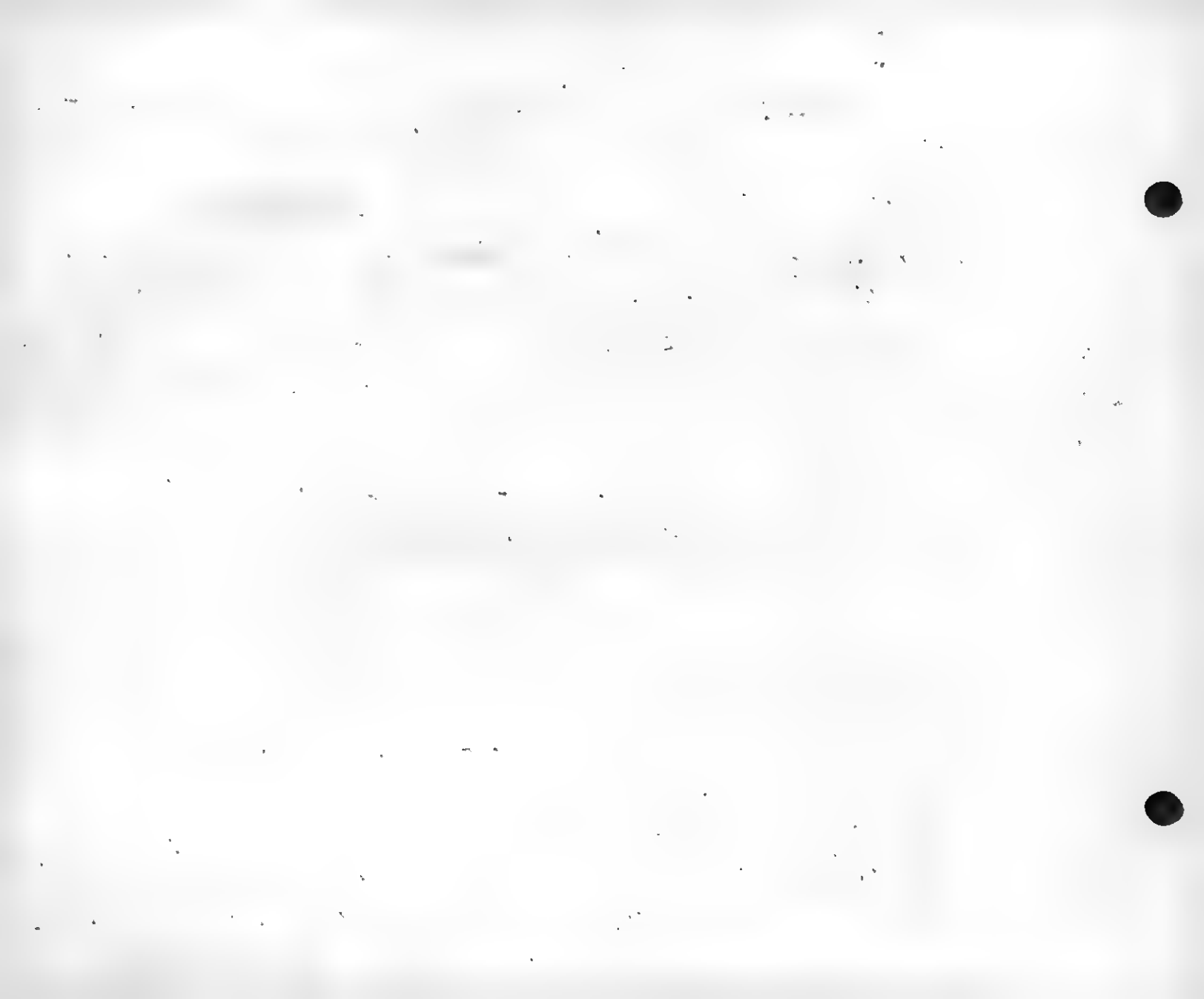
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1 DECEASED-NAME (Type or Print)			First Middle Last			2a DATE KNOWN OF DEATH			2b HOUR
JEANIE NMI SIEGEL						Month Day Year			10AM
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (in years last birthday)	IF UNDER 1 YEAR		F UNDER 24 HRS		2c DATE PRONOUNCED DEAD	
Female	White	7/18/94	72 YRS	MONTHS	DAYS	HOURS	MIN	Month Day Year	10A M
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH			
Rumania		USA				Montgomery Md			
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY	
Silver Spring			Holy Cross Hospital			Seamstress		Clothing	
13a USUAL RESIDENCE (Where deceased resided, if institution Residence before admission)			13b CITY OR TOWN		13c INSIDE CITY LIMITS?		13e STREET AND NUMBER		
New York			Bronx		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		24 E 176 st bronx NY		
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME			ADDRESS			
Unknown			Unknown			neice Thelma Becker 8201 16th St. Sil.Sprg. Md.			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO		17. INFORMANT		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
no					neice Thelma Becker				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)									
4129 Acute Coronary Insufficiency									
DUE TO, OR AS A CONSEQUENCE OF									
(b) Arteriosclerotic Heart Disease									
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
- 22 -									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?			
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			21b. TIME OF INJURY Month, Day Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
			P.M. 19						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No		City or Town		County State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE			CHIEF MEDICAL EXAMINER			22b. DATE SIGNED			
Belden R. Resp						July 19, 1968			
EXAMINER'S NAME (Type)			DEPUTY MEDICAL EXAMINER			ADDRESS (Street, City or Town, County, State)			
Belden R. Resp									
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town, County, State)			
Burial		July 21, 1968		Mt. Vernon Cem		Queens L.I. N.Y.			
24. FUNERAL DIRECTOR			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE			
B. Wanyandky & Sons			JUL 23 1968			J. Charles Judge			

1. DECEASED-NAME (Type or print) Samuel			First Middle Last SILVERMAN			2a. DATE OF DEATH Month 7 Day 29 Year 68			2b. HOUR 7:30 P		
3. SEX M			4. RACE White			5. DATE OF BIRTH 11/12/08			6. AGE (In years lost birthday) 59 YRS		
7a. BIRTHPLACE (State or foreign country) D.C.			7b. CITIZEN OF WHAT COUNTRY? U.S.A			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Montgomery Md.		
10. CITY OR TOWN OF DEATH Silver Spring			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Holy Cross Hosp			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) UNIT DRIVER			12b. KIND OF BUSINESS OR INDUSTRY DIAMOND CAR		
13a. USUAL RESIDENCE (Where deceased lived, if institution-Residence before admission) STATE MD			13b. COUNTY MONTE			13c. CITY OR TOWN SL SPR.			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME First Middle Last Harvey SILVERMAN			15. MOTHER'S MAIDEN NAME First Middle Last RACHEL SPRUNCK			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no			16b. SOCIAL SECURITY NO 578-03-345		
17. INFORMANT SADIE SILVERMAN			Address SPRINGER 13			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Coronary Insufficiency DUE TO, OR AS A CONSEQUENCE OF (b) Perforation, lower caecum, localized DUE TO, OR AS A CONSEQUENCE OF (c) peritonitis, bronchopneumonia			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 5501											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from July 29, 1968 to July 29, 1968 , that (I) (we) last saw the deceased alive on July 29, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Sydney Leventhal, M.D.			22c. DATE SIGNED 7/29/68			22d. PHYSICIAN'S NAME (Type) Sydney Leventhal, M.D.			22e. ADDRESS 9210 Colesville Rd. Silver Spring Md.		
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE 7-31-68			23c. NAME OF CEMETERY OR CREMATORY D.C. 10000 Cem			23d. LOCATION (City or Town) (County) (State) BETHESDA		
24. FUNERAL DIRECTOR GOLDBERG FUN' Home			ADDRESS 4217 9th NW. WASH DC			25a. REC'D BY REGISTRAR AUG 1 1968			25b. REGISTRAR'S SIGNATURE Charles Judge		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

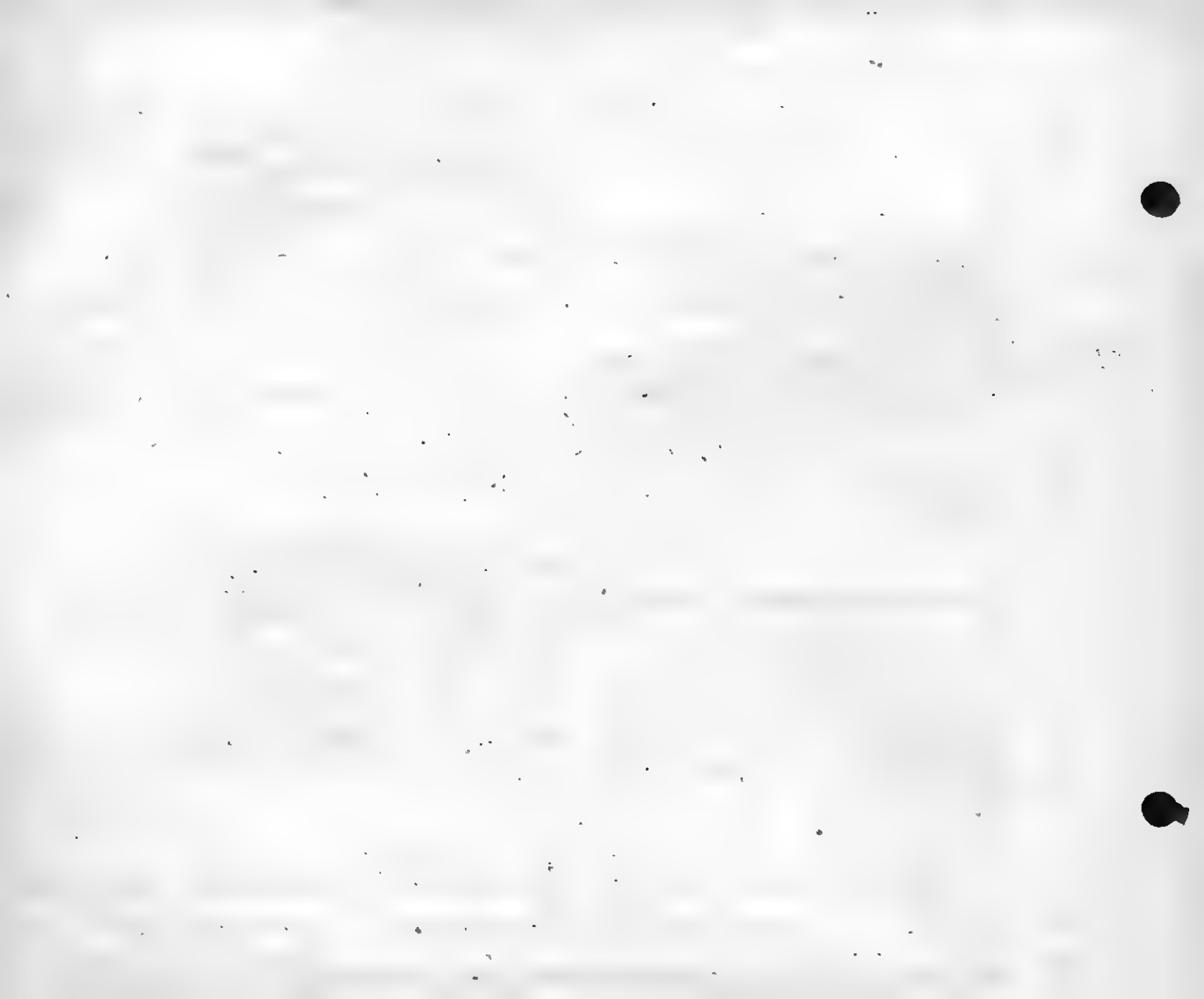


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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) JAMES E. wing SIMPSON			2a. DATE OF DEATH Month 7 Day 17 Year 68			2b. HOUR 3 P M			
3. SEX Male		4. RACE White		5. DATE OF BIRTH 9/19/00		6. AGE (In years lost birthday) 68 yrs		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) New York City		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery			
10. CITY OR TOWN OF DEATH Silver Spring Md.		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Holy Cross Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) foreman - Pepco		12b. KIND OF BUSINESS OR INDUSTRY Electric			
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Wheaton		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 11504 Galt Ave. Wheaton	
14. FATHER'S NAME First James Middle NMI Last Simpson			15. MOTHER'S M.A.DEN NAME First Agnes Middle ? Last Sampson						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) yes		(If yes give year or dates of service) WW I		16b. SOCIAL SECURITY NO. 577-09-3277		17. INFORMANT Address wife Agnes 11504 Galt Ave. Wheaton, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) White Coronary Insufficiency 4129 DUE TO, OR AS A CONSEQUENCE OF (b) Coronary Artery Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c) Pulmonary Emphysema Severe PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from April 19 68 to July 17 19 68 , that (I) (we) lost saw the deceased alive on June 28 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Walden K. Beep		DEGREE M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 7/18/68			
22d. PHYSICIAN'S NAME (Type) WALDEN K. BEEP, M.D.		22e. ADDRESS Wheaton Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE July 20, 1968		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Mausoleum		23d. LOCATION (City or Town) (County) (State) Prince George Co. Md.			
24. FUNERAL DIRECTOR Warner E. Humphrey, Inc.		24a. ADDRESS 8434 Georgia Ave. Silver Spring, Md.		25a. REC'D BY REGISTRAR JUL 24 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			

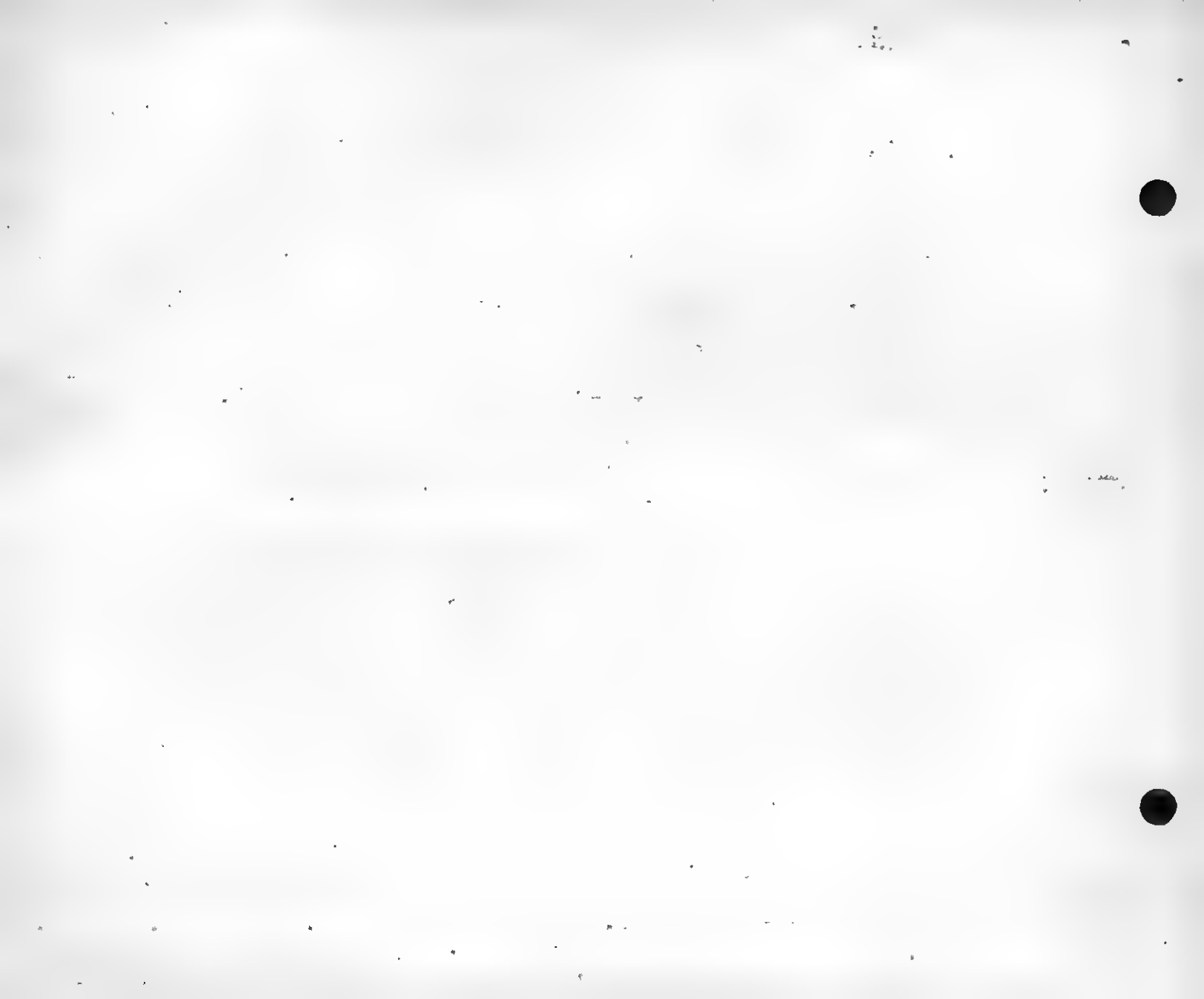


CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR M		
HELEN		E		SIMS	July 31, 1968				
3 SEX	4 RACE		5. DATE OF BIRTH		6 AGE (In years at birthday)		7 UNDER 1 YEAR MONTHS DAYS		
Female	White		Jan 16 1915		53 YRS.				
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH			
Mich		USA				Montgomery Md.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR IND. STRY			
Bethesda		9300 Linden Avenue		Reviewer		US Govt.			
13a. USUAL RESIDENCE (Where deceased lived, if admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Md.		Montgomery		Bethesda		YES <input type="checkbox"/> NO <input type="checkbox"/>		9300 Linden Ave	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME							
Ray		Newton Sims		Ila Ayers					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17 INFORMANT					
No		none		Address Rockville Md					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Seizure</u>		30 minutes							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		(b) <u>Brain Tumor (Astrocytoma)</u>							
		(c) <u>Brain Tumor (Astrocytoma)</u>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)		1930							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>July 31</u> , 19 <u>68</u> , to <u>July 31</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>July 31</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Fred A. Gill</u>		22c. DATE SIGNED 8-1-68							
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS							
FRED A. GILL		4743 Bradley Blvd. Chevy Chase, Maryland							
23a. BURIAL, CREMATION, REMOVAL (Type)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		8-3-68		Ft. Lincoln		Mt. Rainer Pr. Geo Md.			
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Robert A Pumphrey 7557 Wisconsin Ave. Bethesda, Md		DATE AUG 5 1968		J. Charles Judge					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201													
CERTIFICATE OF DEATH													
1 DECEASED-NAME (Type or print)			First		Middle		Last		2a. DATE OF DEATH			2b. HOUR	
Marguerite							Slote		July 7 1968			11 ¹⁰ PM	
3. SEX		4 RACE		5. DATE OF BIRTH				6. AGE (in years last birthday)		7. UNDER 1 YEAR		8. UNDER 24 HRS.	
Female		white		8-4-87				80 YRS.		MONTHS		DAYS	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED		9 NEVER MARRIED		9 COUNTY OF DEATH					
New York		USA		WIDOWED		DIVORCED		Montgomery					
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)				12a. USUAL OCCUPATION (kind of work done during most of work life, even if retired)				12b. KIND OF BUSINESS OR INDUSTRY	
Bethesda				Suburban				Retired					
13a. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LOT 157		13e. STREET AND NUMBER			
Maryland				King George		Bethesda		YES		NO		9901 Rockwood Ave	
14 FATHER'S NAME				15 MOTHER'S MAIDEN NAME		First		Middle		Last			
Homer Francis Jaffer				Harriett Newcombe									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown				16b. SOCIAL SECURITY NO		17 INFORMANT		Address					
No				No		McFrancis Jaffer Slote		Above					
18 CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c))												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral thrombosis												12 hrs	
DUE TO, OR AS A CONSEQUENCE OF (b) Generalized arteriosclerosis												54m	
DUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
3 previous cerebral thrombosis & residua													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
								YES		NO			
21a. ACCIDENT WAS UNDERLYING				21b. TIME OF INJURY				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				HOUR A.M. Month Day Year									
21d. INJURY OCCURRED				21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)				21f. LOCATION Street or R.F.D. No. City or Town County State					
While <input type="checkbox"/> Not while <input type="checkbox"/>													
22a. I certify that (I) (this hospital) attended the deceased from 7 July, 1968, to 7 July, 1968, that (I) (we) last saw the deceased alive on 7 July, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE				22c. DATE SIGNED									
Eugene P. Libre M.D.				7 July 1968									
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS									
EUGENE P. LIBRE				10400 CONN. AVE. PENSINGTON, MD.									
23a. B. RIAL CREMATION, REMOVAL (Specify)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
Burial				July 11 1968		Woodlawn Cem.		New York City		N.Y.			
24. FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR				25b. REGISTRAR'S SIGNATURE					
Robert A. Murphy				JUL 11 1968				Charles Judge					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR 116 (A)
30M REV 11/68

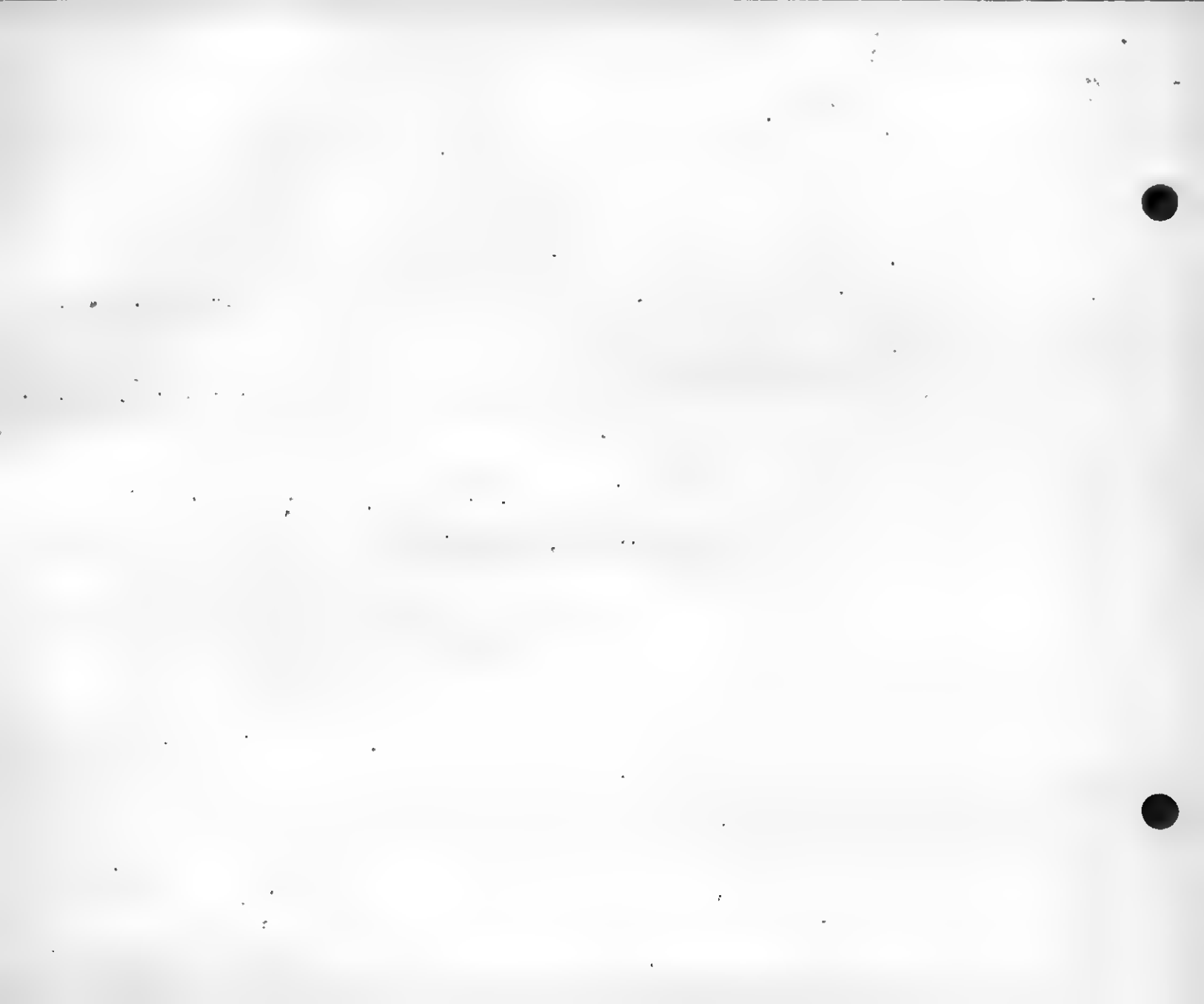
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1 DECEASED NAME (Type or print) LOUIS			First A Middle Sledge Last			2a. DATE OF DEATH Month 7 Day 26 Year 68			2b. HOUR 12:55 PM
3. SEX Male		4. RACE White		5. DATE OF BIRTH 2/24/29		6. AGE (In years last birthday) 39 YRS		IF UNDER 1 YEAR MONTHS 0 DAYS 0 HOURS 0 MIN 0	
7a. BIRTHPLACE (State or foreign country) D.C.		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md			
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Holy Cross Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) PBX repairman		12b. KIND OF BUSINESS OR INDUSTRY GP Tel Co			
13a. USUAL RESIDENCE (Where deceased admission) STATE MD		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY, Y.M.? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 12208 Livingston St	
14 FATHER'S NAME HERBERT AUSTIN SLEDGE			First A Middle S Last SLEDGE			15 MOTHER'S MAIDEN NAME VALERIA MULLICAN			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown YES		16b. SOCIAL SECURITY NO -		17 INFORMANT MARY C. SLEDGE Address					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) coronary arteriosclerosis with 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) occlusion of R/(old) & L/(recent) DUE TO, OR AS A CONSEQUENCE OF coronary arteries (c) myocardial infarction & fibrosis, L/ventricle									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c) 4201									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. 19 Month 7 Day 26 Year 68		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No 6119/68		City or Town 7/26/68		County St. Sp. Md.	
22a. I certify that (I) (this hospital) attended the deceased from 6/19/68 , to 7/26/68 , that (I) (we) last saw the deceased alive on 7/25/68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE John J. Curry M.D.				22c. DATE SIGNED 7/26/68		22d. PHYSICIAN'S NAME (Type) John J. Curry M.D.			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 7-29-68		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill		23d. LOCATION (City or Town) Snellend		(County) (State)	
24. FUNERAL DIRECTOR Joseph Gowler's Sons, 5130 Wiscy Ave.				25a. REC'D BY REGISTRAR JUL 31 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			



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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1 DECEASED-NAME (Type or print) First - CLEO Middle L. Last SMIT			2a. DATE OF DEATH Month 7 Day 15 Year 68			2b. HOUR 2:42 M			
3 SEX F		4 RACE W		5 DATE OF BIRTH 10-16-1897		6 AGE (In years last birthday) 70 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) NEW YORK		7b. CITIZEN OF WHAT COUNTRY? U.S. A.		8 MARRIED <input type="checkbox"/> NEVER MARR ED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md			
10 CITY OR TOWN OF DEATH Kensington		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) KENSINGTON GORD. 1000 MONTGOMERY AVE.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY -			
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE M.D.		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN Cherry Chase		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER H823 Cherry Chase Blvd.	
14. FATHER'S NAME First ANTHONY Middle - Last DANZI			15. MOTHER'S MAIDEN NAME First LILLIE Middle DELMONICO Last -			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO (If yes, give war or dates of service)			
16b. SOCIAL SECURITY NO 5 79-48 4232A			17 INFORMANT MRS. FRANK MANNARINO, DAUGHTER			Address SAME AS 13e.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cachexia DUE TO, OR AS A CONSEQUENCE OF metastatic carcinoma, primary site unknown. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) - DUE TO, OR AS A CONSEQUENCE OF - (c) Adenocarcinoma, recto-sigmoid								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 yrs. 2 years	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 6-29-1968 , 19 68 , that (I) (we) last saw the deceased alive on 6-29-1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Geo. A. Gray, Jr. M.D.		22c. DATE SIGNED 7/15/68		22d. PHYSICIAN'S NAME (Type) GEO. A. GRAY, JR. M.D.		22e. ADDRESS 4140 Cherry Chase Drive, Chevy Chase, Md.			
23a. BURIAL, CREMATION, REBURY, Etc. Burial		23b. DATE 7-18-1968		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City or Town) (County) (State) Arlington, County, Virginia			
24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc., 5130 Wiso. Ave. N.W., Wash., D.C., 20016				25a. RECEIVED BY REGISTRAR JUL 17 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

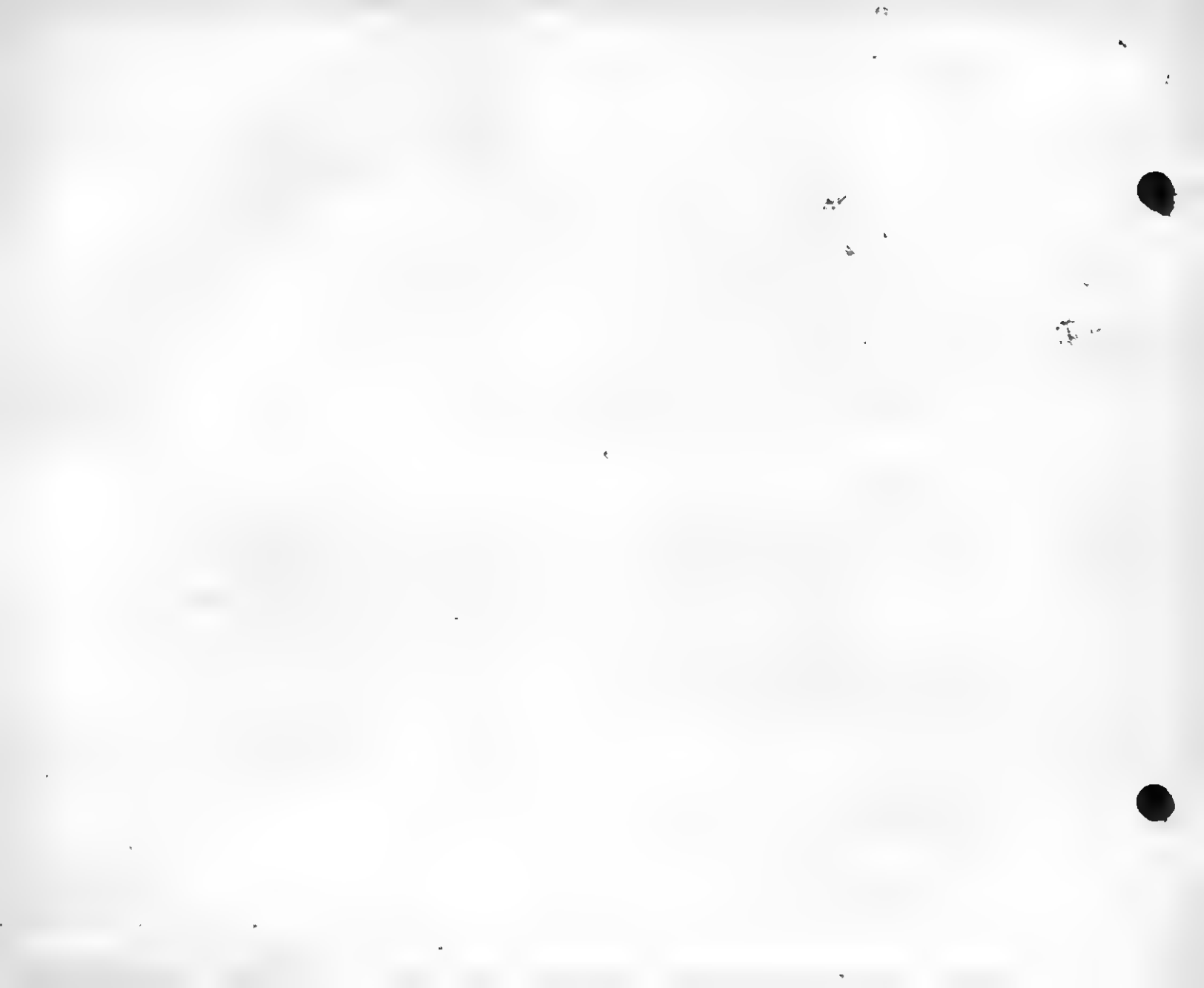
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VR A15-74
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) Brigit Schaller Smith			2a. DATE OF DEATH Month July Day 22 Year 68			2b. HOUR 5:30 AM					
3. SEX Female		4 RACE white		5. DATE OF BIRTH June 23-1966		6. AGE (In years last birthday) 2 YRS		IF UNDER 1 YEAR MONTHS _____ DAYS _____		IF UNDER 24 HRS. HOURS _____ MIN. _____	
7a. BIRTHPLACE (State or foreign country) Washington, D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.					
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Suburban Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) CHILD		12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE MARYLAND		13b. COUNTY Montgomery		13c. CITY OR TOWN Potomac		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 9621 Falls Road			
14. FATHER'S NAME First EARL Middle Clarence Last Smith		15. MOTHER'S MAIDEN NAME First KATHLEEN Middle Smythe Last Smythe									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. NONE		17. INFORMANT Father E.C. Smith - ABOVE Address							
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) VIREMIA, acute 0799 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 days	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
MEDICAL CERTIFICATION											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or RFD No		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from 7-15 , 19 68 , to 7-22 , 19 68 , that (I) (we) last saw the deceased alive on 7-22 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE John E. Cassidy M.D.				DEGREE MD		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 7-22-68			
22d. PHYSICIAN'S NAME (Type) JOHN E. CASSIDY MD				22e. ADDRESS 9911 OLD GEORGETOWN RD. BETHESDA							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 7/24/68		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery, Sil. Spring, Montg. Md		23d. LOCATION (City or Town)		(County)		(State)	
24. FUNERAL DIRECTOR Robert A. Pumphrey, Bethesda, Maryland				7557 ADDRESS Wisconsin Ave.		25a. REGD BY REGISTRAR JUL 24 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper - Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
Item #6, Film G402 7/11/68 km									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year		2b. HOUR	
George			Harley			SMITH		July 3 1968 8:45pM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. IF UNDER 1 YEAR	
Male		Caucasian		July 10, 1906		61 65 YRS.		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH		10. CITY OR TOWN OF DEATH	
Georgia		U. S.				Montgomery		Bethesda	
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY					
Naval Hospital, Bethesda		U. S. Navy							
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Georgia				Dixie				P.O. Box 6	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
John D. SMITH			Annie Rebecca GIBBS						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES			16b. SOCIAL SECURITY NO.		17. INFORMANT		Address		
			266-40-0286		Mrs. Edna E. ROYAL		1069 Central Av. Needham, Mass.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART I. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) <u>Pancreatic carcinoma with widespread visceral metastases</u>									
DUE TO, OR AS A CONSEQUENCE OF (b) _____									
DUE TO, OR AS A CONSEQUENCE OF (c) _____									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
57x									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or RFD No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>13 JUNE</u> , 19 <u>68</u> , to <u>3 JULY</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>3 JULY</u> , 19 <u>68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death									
22b. SIGNATURE <u>Francis C. Johnson</u>					22c. DATE SIGNED <u>5 July 1968</u>				
22d. PHYSICIAN'S NAME (Type) <u>Francis C. Johnson, M. D.</u>					22e. ADDRESS <u>Naval Hospital, Bethesda, Md.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		7-5-1968		Dixie Cemetery		Dixie, Georgia			
24. FUNERAL DIRECTOR <u>Joseph Gawler Sons</u>					25a. REC'D BY REG. STRAR <u>DUL-9 1968</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>		
5130 Wisconsin Ave., N. W. Washington, D. C.									



CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

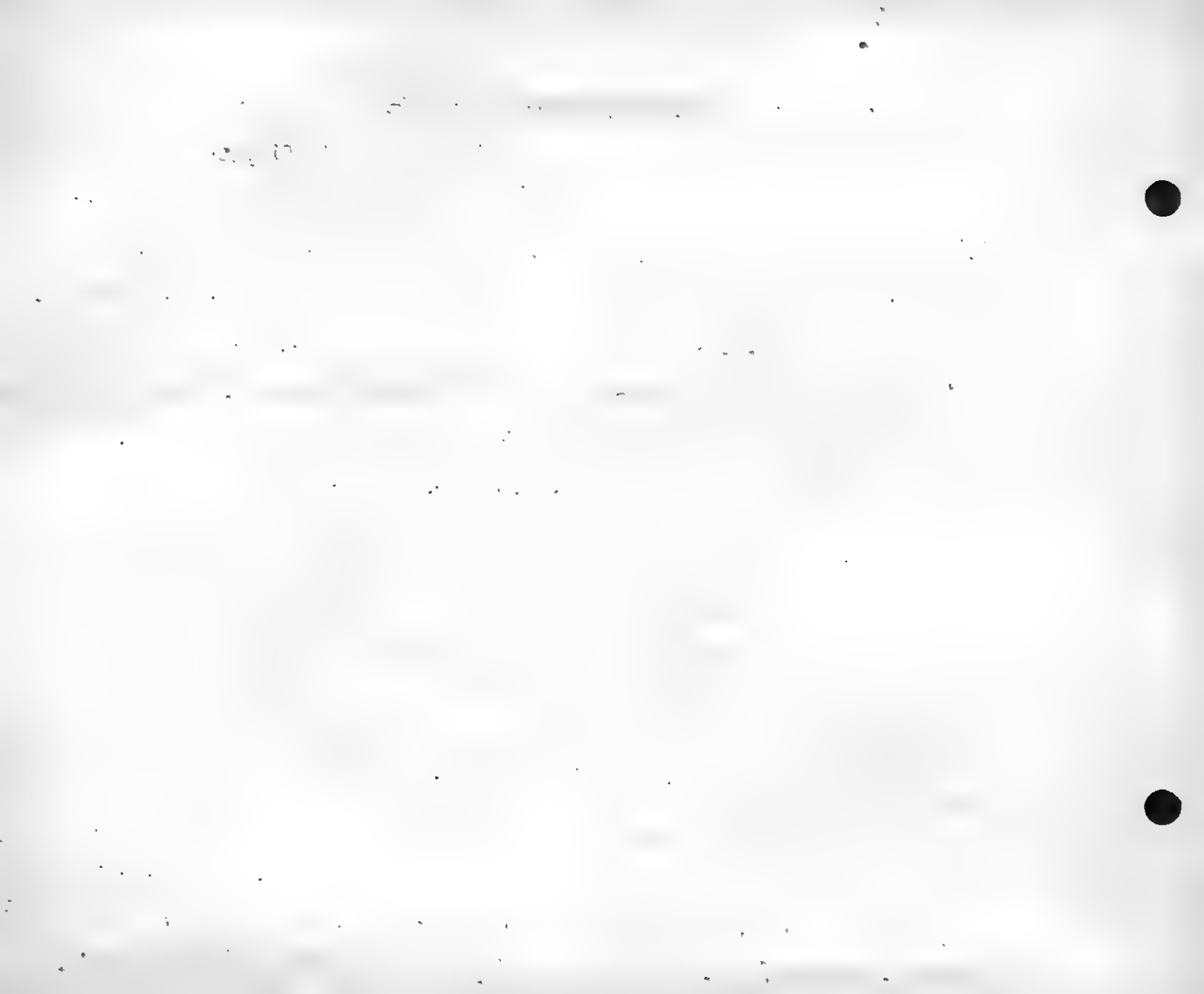
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) and should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) <u>Harley</u> First <u>Robert</u> Middle <u>Lee</u> Last <u>Smith</u>			2a. DATE OF DEATH Month <u>7</u> Day <u>12</u> Year <u>1968</u>			2b. HOUR <u>2:00</u> M	
3 SEX <u>Male</u>		4 RACE <u>White</u>		5. DATE OF BIRTH <u>5-22-1922</u>		6 AGE (in years lost birthday) <u>46</u> YRS	
7a. BIRTHPLACE (State or foreign country) <u>Indiana, Ohio</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <u>Montgomery</u> Md	
10. CITY OR TOWN OF DEATH <u>Acron, Mo</u>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>St. Elizabeth's Hospital</u>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) STATE <u>Mo</u>		13b. COUNTY <u>St. Louis</u>		13c. CITY OR TOWN <u>St. Louis</u>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET AND NUMBER <u>2240 DelRay Ave</u>		14. FATHER'S NAME First <u>Harley</u> Middle <u>Robert</u> Last <u>Smith</u>		15. MOTHER'S MAIDEN NAME First <u>Edith</u> Middle <u>Loop</u> Last <u>Loop</u>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL THROMBOSIS, RECURRENT</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: <u>337x</u> (b) <u>ARTERIOSCLEROSIS, CEREBRAL</u> DUE TO, OR AS A CONSEQUENCE OF (c)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>10 MONTHS</u> <u>54 YEARS</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>CEREBRAL SPINAL LUES</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <u>19</u>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>MARCH 1, 1968</u> to <u>JULY 12, 1968</u> , that (I) (we) last saw the deceased alive on <u>JULY 9, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Robert G. Angle</u> M.D.		DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>JULY 12 1968</u>	
22d. PHYSICIAN'S NAME (Type) <u>Robert G. Angle</u>		22e. ADDRESS <u>5009 DelRay Ave, Bethesda Md</u>					
23a. BURIAL, CREMATION, REMOVAL (Type) <u>Burial</u>		23b. DATE <u>7-15-68</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		23d. LOCATION (City or Town) (County) (State) <u>Suitland Pr. Geo Md</u>	
24. FUNERAL DIRECTOR <u>Robert A. Humphrey</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>JUL 16 1968</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1 DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH			2b. HOUR
MARV SMITH SMITH						Month	Day	Year	8:15 PM
3 SEX		4 RACE		5. DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
F		W		7-18-12		25			
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
DC		USA				MONTGOMERY Md.			
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY			
TAKOMA PARK		WASH SANITARIUM		SECT DEPT of ARMY					
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER	
MD		MONTG		SS				2404 Homestead Dr.	
14 FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First Middle Last
Maurice E. SHEEHY						JOSEPHINE REGAN			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, (up, or unknown) No			16b SOCIAL SECURITY NO		17 INFORMANT		Address		
			579-24-8008		George W. Smith same as above				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Subarachnoid hemorrhage +309 DUE TO, OR AS A CONSEQUENCE OF (b) Probable aneurysmal rupture DUE TO, OR AS A CONSEQUENCE OF (c)									54 hrs
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from 7/23/1968, to 7/25/1968, that (I) (we) lost the deceased alive on 7/25/1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (Type)					
Benne G. Bendler MD		7/25/68		Benne G. Bendler Md					
22e. ADDRESS		22f. ADDRESS							
10820 Georgia Ave. Wheaton Md.									
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County) (State)	
Burial		July 29, 1968		Gate of Heaven Cemetery		Silver Spring, Maryland			
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
C. Glen Warner E. Pumphrey, Inc.		JUL 31 1968		Charles Judge					



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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
Items#13c&13e Film#G402 7/25/68 CERTIFICATE OF DEATH											
1 DECEASED NAME (Type or print) CHARLOTTE EMM A SNELLING						2a DATE OF DEATH Month 7 Day 14 Year 68			2b HOUR 11A M		
3. SEX FEMALE		4 RACE WHITE		5. DATE OF BIRTH Nov 6, 182 11/6/1882		6 AGE (In years lost birthday) 85 YRS		IF UNDER 1 YEAR MONTHS _____ DAYS _____		IF UNDER 24 HRS HOURS _____ MIN _____	
7a BIRTHPLACE (State or foreign country) NEW YORK		7b. CITIZEN OF WHAT COUNTRY? U.S.A		B MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH MONTGOMERY Md.					
10 CITY OR TOWN OF DEATH SILVER SPRING			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) ALTHEA WOODLAND			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) HOUSEWIFE			12b KIND OF BUSINESS OR INDUSTRY _____		
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE MARYLAND			13b COUNTY MONTGOMERY		13c CITY OR TOWN SILVER SPRING		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 10001 TALENT VIEW DRIVE		
14. FATHER'S NAME First Middle Last SAMUEL SMITH			15 MOTHER'S M maiden name First Middle Last RACHEL MOYSE								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or (unknown) (If yes give war or dates of service) NO			16b. SOCIAL SECURITY NO. NO		17. INFORMANT (Mrs) FLSIE HENDRICKS			Address 7106 - 45th CHERRY CHASE			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL HEMORRHAGE 4-1-1 DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIO-SCLEROSIS DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 HOUR MANY YEARS	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 331X NONE											
19a. DATE OF OPERATION NO		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED NO			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? _____				
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. _____ Month _____ Day _____ Year _____ P.M. _____ 19 _____		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21b. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. _____		City or Town _____		County _____		State _____	
22a. I certify that (I) (this hospital) attended the deceased from NOV 1966 , to JULY 13 1968 , that (I) (we) last saw the deceased alive on JULY 13 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b SIGNATURE Bradley C. Hodgkins M.D.					DEGREE MD		ATTENDING PHYS. <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 7/14/68		
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS						
23a BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b DATE 7/17/68		23c. NAME OF CEMETERY OR CREMATORY Lee's Crematory			23d. LOCATION (City or Town) (County) (State) Washington D.C.				
24. FUNERAL DIRECTOR Funeral Home		ADDRESS Wash D.C.		25a REC'D BY REGISTRAR DATE JUL 17 1968		25b REGISTRAR'S SIGNATURE Charles Judge					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1 DECEASED NAME (Type or print) First Middle Last Fannie Margaret Snyder			2a DATE OF DEATH Month Day Year July 24 1968			2b HOUR 6 PM			
3 SEX Female		4 RACE Cauc.		5 DATE OF BIRTH Aug 13, 1899		6 AGE (In years last birthday) 68 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a BIRTHPLACE (State or foreign country) Penn.		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Montgomery Md.			
10 CITY OR TOWN OF DEATH Wheaton		11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) University of Maryland School of Medicine		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Waitress		12b KIND OF BUSINESS OR INDUSTRY			
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Penn.		13b COUNTY Somerset		13c CITY OR TOWN Meyersdale		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 227 Center St.	
14 FATHER'S NAME First Middle Last Wilson Miller			15 MOTHER'S MAIDEN NAME First Middle Last Ida Hostetler			16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) no			
16b SOCIAL SECURITY NO. 165-22-0265			17 INFORMANT Mrs. K. Snyder			18 ADDRESS 10106 Oaklark Kensington, Md.			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) glioblastoma multiforme 1929 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 1929									
19a DATE OF OPERATION 1929		19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21a INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21b PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21c LOCATION Street or R.F.D. No		City or Town		County State	
22a I certify that (I) (this hospital) attended the deceased from 20 July, 1968 to 24 July, 1968 , that (I) (we) last saw the deceased alive on 24 July, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE Walter E. Goetz				DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c DATE SIGNED 24 July 68			
22d PHYSICIAN'S NAME (Type) WALTER E. GOETZ				22e ADDRESS 2309 SHOREFIELD RD, WHEATON, MD.					
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE July 26, 1968		23c NAME OF CEMETERY OR CREMATORY Union Cemetery		23d LOCATION (City or Town) (County) (State) Meyersdale, Pennsylvania		25a REC'D BY REGISTRAR Charles Judge	
23d GENERAL DIRECTOR'S SIGNATURE Warner E. Pumphrey, Inc.		23e ADDRESS 434 Georgia Ave. Silver Spring, Md.		25a DATE JUL 29 1968		25b REGISTRAR'S SIGNATURE			



CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) Max E. Snyder			2a. DATE OF DEATH 7 Month 10 Day 68 Year			2b. HOUR 7 AM				
3 SEX Male		4. RACE White		5. DATE OF BIRTH 10-24-96		6 AGE (In years lost birthday) 71 YRS		7 F UNDER YEAR MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (State or foreign country) Russia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.				
10. CITY OR TOWN OF DEATH Silver Spring			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Holy Cross Hosp.			12a USJAL OCCUPATION (Kind of work done during most of working life, even retired) Grucker (Ret.)			12b KIND OF BUSINESS OR INDUSTRY Food	
13a USJAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.			13b COUNTY Montgomery		13c CITY OR TOWN Silver Spring		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 8510 16th Street	
14. FATHER'S NAME First Middle Last NATHANIEL SNYDER			15. MOTHER'S MAIDEN NAME First Middle Last YAHLEVIT FELDMAN							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO (If yes give war or dates of service)			16b SOCIAL SECURITY NO 577-48-2259A		17 INFORMANT SADIE SNYDER				Address JAME AS 13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardio-Respiratory failure										
DUE TO, OR AS A CONSEQUENCE OF										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost										
(b) Metastatic Carcinoma of the Colon										
DUE TO, OR AS A CONSEQUENCE OF										
(c)										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e PLACE OF INJURY (At home, farm, street, factory, office building, etc)			21f LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from OCT. 16 , 19 67 , to JULY 10 , 19 68 , that (I) (we) lost saw the deceased alive on July 9 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Bernard A. Heckman, M.D.						DEGREE ATTENDING <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 7-10-68		
22d. PHYSICIAN'S NAME (Type) Bernard A. Heckman, M.D.						22e ADDRESS 8107 Eastern Ave. Silver Spring, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE 7-11-68		23c. NAME OF CEMETERY OR CREMATORY BETH SHOMON Cem.			23d. LOCATION (City or Town) (County) (State) CAPITOL HEIGHTS MD		
24. FUNERAL DIRECTOR Joseph J. ...						25a. REC'D BY REGISTRAR JUL 15 1968		25b. REGISTRAR'S SIGNATURE Charles Judge		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) Shirley M Sobel					2a. DATE OF DEATH July Month 23 Day 68 Year			2b. HOUR 6:25A	
3 SEX Female		4. RACE Caucasian		5. DATE OF BIRTH 20 October 1919		6. AGE (In years last birthday) 48 YRS		7. FUNERAL YEAR MONTHS DAYS	
7a. BIRTHPLACE (State or foreign country) Connecticut		7b. CIT ZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.			
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Naval Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Nurse			12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 4305 Federal Street	
14. FATHER'S NAME First Louis J Middle Monat Last					15. MOTHER'S MAIDEN NAME First Jean E Middle Rachstein Last				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown Yes		16b. SOCIAL SECURITY NO. 062-05-4680		17. INFORMANT Address Samuel Sobel 4305 Federal St Rockville, Md					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinoma of Breast metastatic to the liver 114 X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) None DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 months	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) 170 X None									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (1) (this hospital) attended the deceased from 12 July , 19 68 , to 23 July , 19 68 , that (X) (we) last saw the deceased alive on 23 July , 19 68 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (not) view the body after death.									
22b. SIGNATURE J.R. Fletcher DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>					22c. DATE SIGNED 23 July 1968				
22d. PHYSICIAN'S NAME (Type) J. R. Fletcher, LT, MC, USN					22e. ADDRESS Naval Hospital Bethesda, Maryland				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 7-25-68		23c. NAME OF CEMETERY OR CREMATORY Beth-Moses Cemetery			23d. LOCATION (City or Town) (County) (State) Pinelawn, Long Island, N.Y.		
24. FUNERAL DIRECTOR B. DANZANSKY, 3501 14th ST. Washington, DC					25a. REC'D BY REGISTRAR JUL 25 1968		25b. REGISTRAR'S SIGNATURE J. Charles Judge		



**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in Item 18. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 10-100-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File Pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

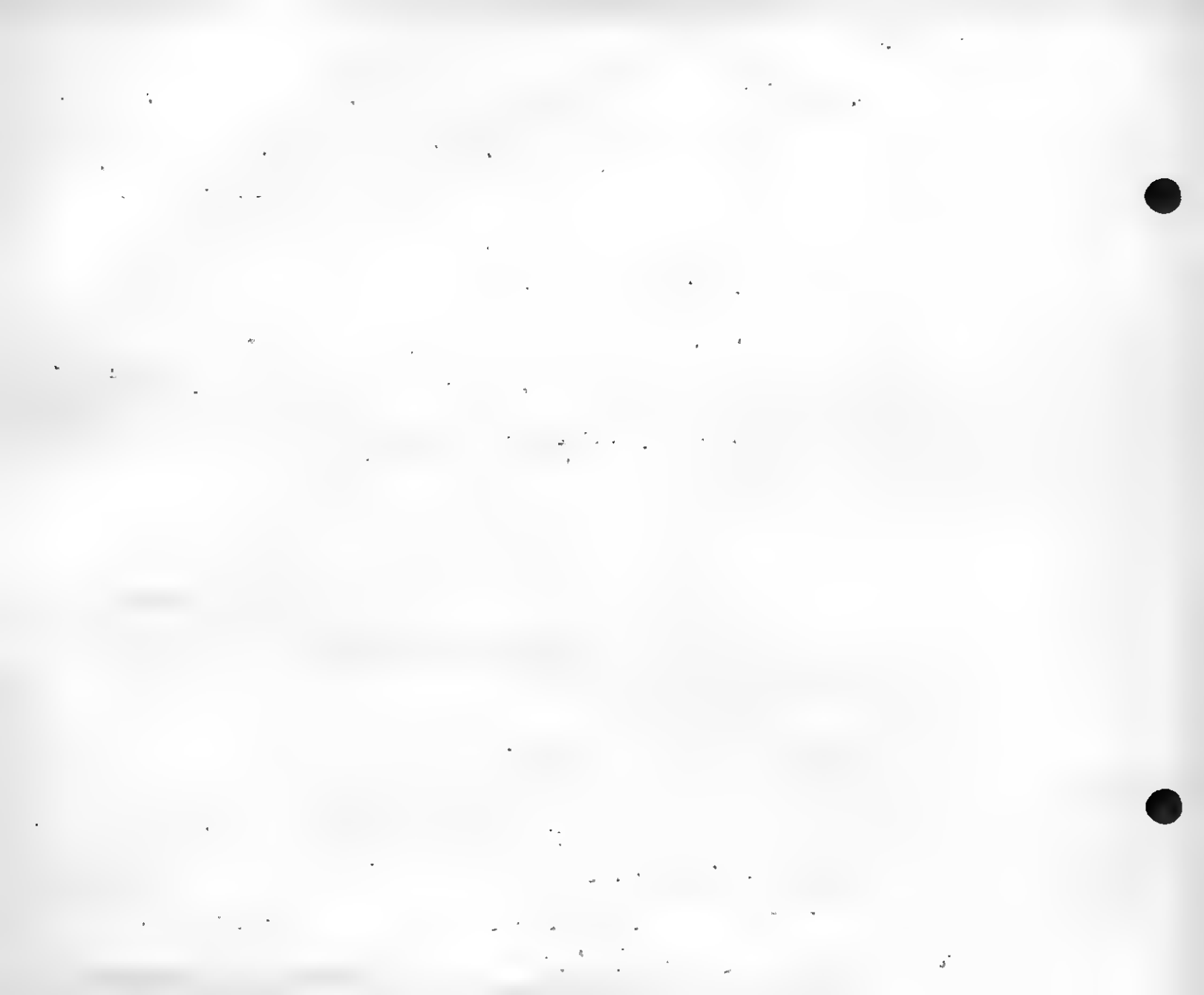
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201															
MEDICAL EXAMINER'S CERTIFICATE OF DEATH															
1 DECEASED NAME (Type or Print)			First <i>John</i>			Middle <i>Howard</i>			Last <i>Solomon</i>			2a DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> <i>July 16 1968</i>		2b HOUR <i>6 PM</i>	
3 SEX <i>M.</i>		4 RACE <i>W.</i>		5 DATE OF BIRTH <i>July 1913</i>		6 AGE (in years last birthday) <i>55</i> YRS		IF UNDER 1 YEAR MONTHS _____ DAYS _____		IF UNDER 24 HRS HOURS _____ MIN _____		2c DATE PRONOUNCED DEAD Month <i>July</i> Day <i>16</i> Year <i>1968</i>		2d HOUR <i>1:15</i> M	
7a BIRTHPLACE (State or foreign country) <i>New York</i>				7b CITIZEN OF WHAT COUNTRY? <i>USA</i>				8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9 COUNTY OF DEATH <i>Montgomery</i>			
10 CITY OR TOWN OF DEATH <i>Bethesda</i>				11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>7507 Bells Mill Rd.</i>				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Medicine & Estate Real Estate</i>				12b KIND OF BUSINESS OR INDUSTRY			
13a U.S.A. RESIDENCE (Where deceased lived, if institution, on residence before admission) STATE <i>Md.</i>				13b COUNTY <i>Montgomery Bethesda</i>				13c CITY OR TOWN <i>Bethesda</i>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER <i>7505 Bells Mill Rd.</i>			
14 FATHER'S NAME First <i>Abraham</i> Middle <i>Solomon</i> Last <i>Solomon</i>						15 MOTHER'S M.A.DEN NAME First <i>Zareef</i> Middle <i>Baroudi</i> Last <i>Baroudi</i>									
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>Yes</i>				16b SOCIAL SECURITY NO <i>W.W. II</i>				17 INFORMANT <i>7507 Bells Mill Rd. Mrs. Lucille B. Solomon, Bethesda, Md.</i>							
18 CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>7800</i> <i>Phenol Overdose of Barbituates and other drugs</i> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 hr. ?</i>			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR A.M. <i>7-16-68</i>				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) <i>Took overdose of drugs</i>							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <i>Home</i>				21f. LOCATION Street or R.F.D. No <i>Bethesda</i>		City or Town <i>Montg</i>		County <i>Md</i>			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>															
ACTUAL SIGNATURE <i>John G. Boll</i>				EXAMINER'S NAME (Type) <i>John G. Boll, M.D.</i>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county)				22b. DATE SIGNED <i>17 July 1968</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>				23b. DATE <i>7/20/68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Family Burying Ground</i>				23d. LOCATION (City or Town) (County) (State) <i>North Creek, Warren, N.Y.</i>					
24. FUNERAL DIRECTOR <i>Robert A. Pumphrey, Bethesda, Maryland</i>				25a. REC'D BY REG. STRAR <i>JUL 22 1968</i>				25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. (The funeral director should remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH									
1. DECEASED NAME (Type or print) First JEFFREY Middle S Last Sombke						2a. DATE OF DEATH Month July Day 23 Year 1968		2b. HOUR 1:25 PM	
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH June 20, 1958		6. AGE (In years last birthday) 10 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery			
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Naval Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) N/A		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE Maryland		13b. COUNTY Prince Georges		13c. CITY OR TOWN Suitland		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 4874 Eastern Lane Apt 303	
14. FATHER'S NAME First Harlowe Middle Earl Last Sombke				15. MOTHER'S MAIDEN NAME First Myrtle Middle Louise Last Moore					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT 4874 Eastern Lane Apt 303 Harlowe E Sombke Suitland, Maryland					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute lymphoblastic leukemia associated with bronchial pneumonia and abscess DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditional, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED White <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from July 20, 1968 , to July 23, 1968 , that (I) (we) last saw the deceased alive on July 23, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death									
22b. SIGNATURE Gary H. Safley DEGREE M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED July 24, 1968			
22d. PHYSICIAN'S NAME (Type) Gary H. SAFLEY, M.D.				22e. ADDRESS Naval Hospital, Bethesda, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 7-26-68		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City or Town) (County) (State) Arlington, Virginia			
24. FUNERAL DIRECTOR Robert E. Wilhelm 4308 Suitland Road, Suitland, Md.				25a. REC'D BY REGISTRAR DATE JUL 29 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			

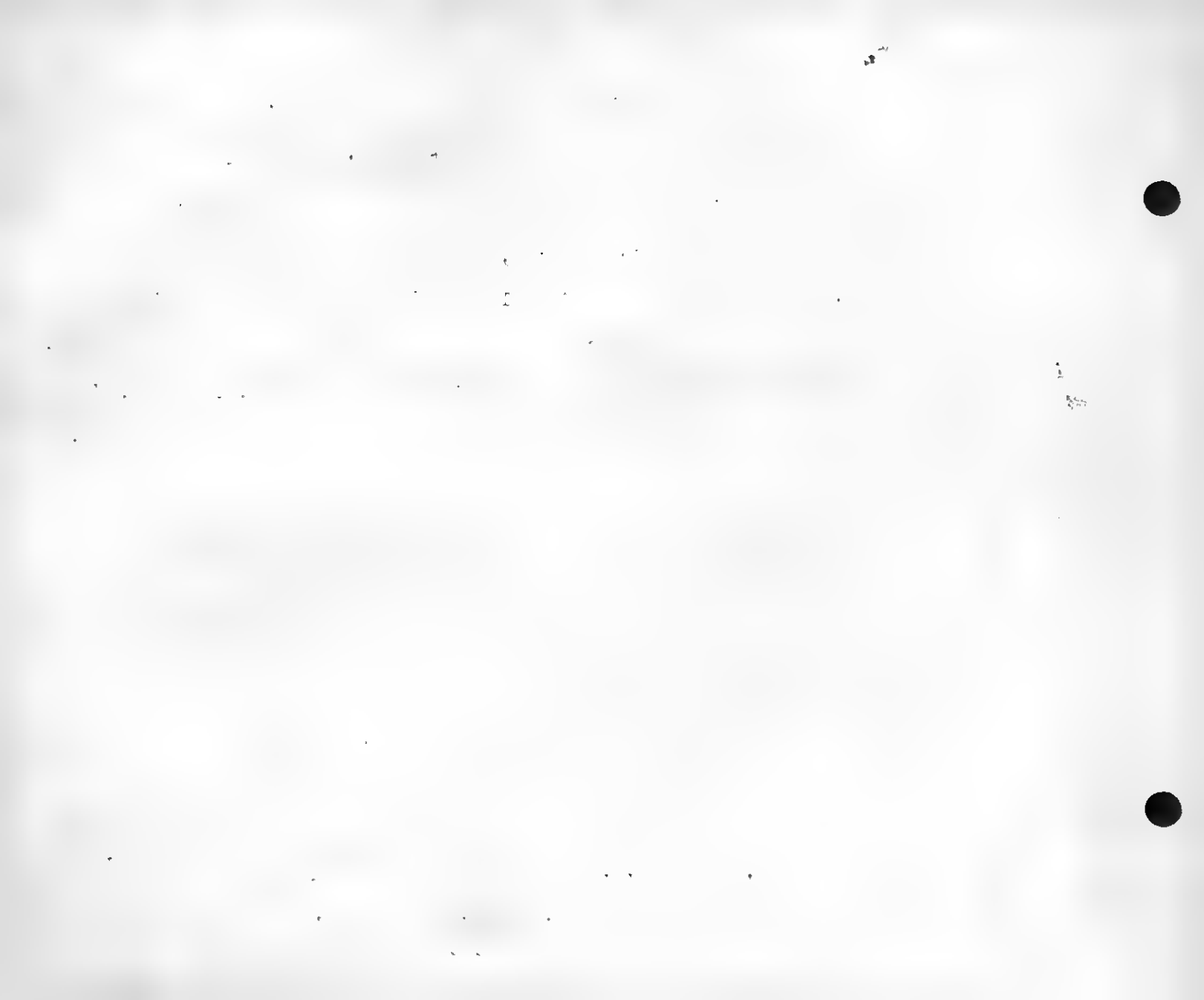


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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) First <u>Anne</u> Middle <u>(none)</u> Last <u>Sommer</u>			2a. DATE OF DEATH Month <u>July</u> Day <u>15</u> Year <u>1968</u>		2b. HOUR <u>10:47 PM</u>
3. SEX <u>Female</u>	4 RACE <u>White</u>	5. DATE OF BIRTH <u>18 September 1896</u>		6 AGE (In years last birthday) <u>71</u> YRS	IF UNDER 1 YEAR MONTHS <u></u> DAYS <u></u>
7a BIRTHPLACE (State or foreign country) <u>Poland</u>		7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <u>Montgomery</u> Md.
10 CITY OR TOWN OF DEATH <u>Bethesda</u>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>The Clinical Center, NIH</u>		12a. USUA. OCCUPATION (Kind of work done during most of working life, even if retired.) <u>Housewife</u>	
12b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <u>New York</u> 13b. COUNTY <u>Brooklyn</u>		13c. CITY OR TOWN <u>Brooklyn</u> 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER <u>2785 Ocean Parkway</u>		14. FATHER'S NAME First <u>Joseph</u> Middle <u>Reichert</u> Last <u>Sommer</u>			
15. MOTHER'S MAIDEN NAME First <u>Sylvia</u> Middle <u></u> Last <u>Sommer</u>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <u>No</u> (If yes give war or dates of service)			
16b. SOCIAL SECURITY NO <u>None</u>		17. INFORMANT <u>The Medical Record</u> Address <u>The Clinical Center, NIH, Bethesda, Maryland</u>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Cryptococcal Meningitis</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>Yes</u>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			
21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <u>19</u>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State	
22a. I certify that <u>(X)</u> (this hospital) attended the deceased from <u>20 May</u> , 19 <u>67</u> , to <u>15 July</u> , 19 <u>68</u> , that <u>(X)</u> (we) last saw the deceased alive on <u>15 July</u> , 19 <u>68</u> , and that in <u>(our)</u> (our) opinion death occurred on the date and hour and from the causes stated above, <u>(X)</u> (we) (did) <u>(not)</u> view the body after death.					
22b. SIGNATURE <u>Anthony S. Fauci</u>		DEGREE <u></u> ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>16 July 1968</u>	
22d. PHYSICIAN'S NAME (Type) <u>Anthony S. Fauci, M.D.</u>		22e. ADDRESS <u>The Clinical Center, National Institutes of Health, Bethesda, Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>July 18, 1968</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Beth David Cemetery</u>	
23d. LOCATION (City or Town) (County) (State) <u>Elmont, New York</u>		24. FUNERAL DIRECTOR <u>Donald M. Stein</u> ADDRESS <u>232 Carroll St., N.W. Wash., D.C.</u>			
25a. REC'D BY REGISTRAR <u>JUL 18 1968</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>			





MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

10364

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) <i>Lorian Margaret Spahn</i>				2a. DATE OF DEATH Month <i>July</i> Day <i>5</i> Year <i>1968</i>				2b. HOUR <i>9-17</i> AM	
3. SEX <i>female</i>		4. RACE <i>white</i>		5. DATE OF BIRTH <i>5-24-16</i>		6. AGE (In years lost birthday) <i>52</i> YRS.		IF UNDER 1 YEAR MONTHS <i></i> DAYS <i></i> HOURS <i></i> MIN. <i></i>	
7a. BIRTH-PLACE (State or foreign country) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i> Md.			
10. CITY OR TOWN OF DEATH <i>Bethesda</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Secretary</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Restaurant Lodge</i>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Maryland</i>		13b. COUNTY <i>Montgomery</i>		13c. CITY OR TOWN <i>Rockville</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>813 E. Jefferson Street</i>	
14. FATHER'S NAME First <i>Charles</i> Middle <i>Margaret</i> Last <i>Spahn</i>		15. MOTHER'S MAIDEN NAME First <i>Lorian</i> Middle <i>Schleiser</i> Last <i></i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i>		16b. SOC. SEC. NO. <i></i>		17. INFORMANT <i>Dr. George Spahn - Above</i> Address <i></i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Renal Failure, Acute</i> <i>571.9</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Cirrhosis of Liver</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <i></i>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 week</i> <i>Uncertain</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <i>April</i> , 19 <i>68</i> , to <i>July</i> , 19 <i>68</i> ; that (I) (we) lost saw the deceased alive on <i>July</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>James W. Egan M.D.</i>		DEGREE <i></i>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (Type) <i>James W. Egan</i>		22e. ADDRESS <i>5413 Cedar Lane - Bethesda</i>							
23a. BURIAL, CREMATION, TRANQUIL (Specify) <i>Burial</i>		23b. DATE <i>7/5/68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Parklawn</i>		23d. LOCATION (City or Town) (County) (State) <i>Rockville, Montg. Md.</i>			
24. FUNERAL DIRECTOR <i>W. J. Heeler Funeral Home</i>		ADDRESS <i>1771 Rockville, Md.</i>		25a. REC'D BY REGISTRAR <i>JUL 5 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages, Pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

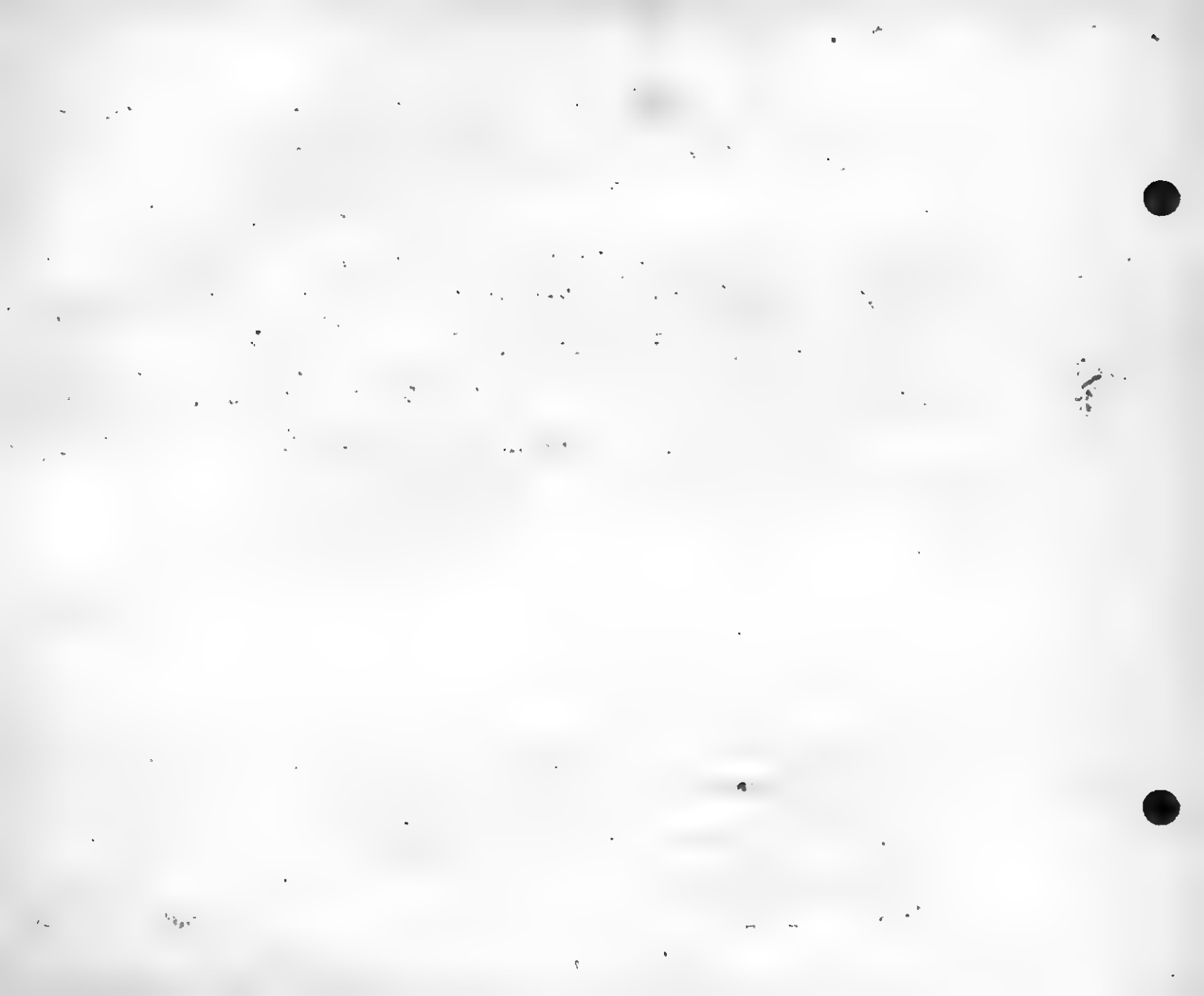
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1 DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR		
Anna Belle			R. Speert			Month 7 Day 6 Year 68		9:30 P.M.		
3 SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years lost birthday)		7. UNDER 1 YEAR		
F		W		4-19-08		60 YRS		MONTHS DAYS HOURS M.N.		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Lithuania		U.S.				Montgomery Md.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY		
Silver Spring			Holy Cross							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
md.			MONT.		Silver Spring		YES		8201 16th Street	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME							
First Middle Last			First Middle Last							
HARRIS			KORKLAN			SARAH Block				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give year or dates of service)			16b. SOCIAL SECURITY NO		17. INFORMANT					
No.					Julius Speert Sr. 1655 55th St. Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Left Heart Failure</u>									24 hrs.	
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Rheumatic Heart Disease</u>									30 years.	
DUE TO, OR AS A CONSEQUENCE OF (c) _____										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
		HOUR A.M. Month Day Year P.M. 19								
21d. INJURY OCCURRED While <input type="checkbox"/> hot while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.)		21f. LOCATION		Street or R.F.D. No.		City or Town		
22a. I certify that (I) (this hospital) attended the deceased from <u>Jan. 1940</u> , to <u>7/6, 1968</u> ; that (I) (we) last saw the deceased alive on <u>7/6, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE					DEGREE		ATTENDING PHYS.		22c. DATE SIGNED	
<u>Samuel Dessoff</u>					MED. DIRECTOR		<input checked="" type="checkbox"/>			
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS					
SAMUEL DESSOFF					1302-188th W. Wash. D.C.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		
		7/8/68		B. Hall Brook Cem		Baltimore		Md.		
24. FUNERAL DIRECTOR					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
B. Damsky 4000 3rd St. N.W. Wash. D.C.					JUL - 9 1968		J. Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1 DECEASED-NAME (Type or print) First Middle Last <i>Louise S. Stackhouse</i>					2a. DATE OF DEATH Month Day Year <i>July 22 1968</i>			2b. HOUR <i>9:27</i> M		
3 SEX <i>Female</i>		4 RACE <i>White</i>		5 DATE OF BIRTH <i>Sept. 27 1912</i>		6 AGE (In years last birthday) <i>56</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS M N		
7a. BIRTHPLACE (State or foreign country) <i>Md.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <i>Montgomery</i> Md				
10 CITY OR TOWN OF DEATH <i>Bethesda</i>			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban Hosp. Nurse</i>			12a. USUAL OCCUPATION (Kind of work done during most of work life, even if retired) <i>Private.</i>		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) STATE <i>Md.</i>			13b. COUNTY <i>Mont.</i>		13c. CIPOR TOWN <i>Rockville</i>		13d. INSIDE CITY LIMITS YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>15 W. Montgomery Ave</i>	
14 FATHER'S NAME First Middle Last <i>James Lee Stanger</i>			15 MOTHER'S MAIDEN NAME First Middle Last <i>Rachel Teller</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>no</i>			16b. SOCIAL SECURITY NO <i>red</i>		17 INFORMANT <i>Will Stackhouse</i>		Address <i>15 N. VanBuren St</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of Colon</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>metastases to liver</i> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>18 mo.</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION <i>1967</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Carcinoma of Colon</i>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.)		21f. LOCATION Street or RFD No City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <i>Aug. 1967</i> , to <i>7/22 1968</i> , that (I) (we) last saw the deceased alive on <i>7/22 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.										
22b. SIGNATURE <i>Arthur F. Woodward M.D.</i>				DEGREE <i>MD</i>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>7/23/68</i>		
22d. PHYSICIAN'S NAME (Type) <i>Arthur F Woodward</i>				22e. ADDRESS <i>15 N. VanBuren St Rockville - Md.</i>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>7-26-68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Rose Hill Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Marietta South Carolina</i>				
24 FUNERAL DIRECTOR <i>Robert A Pumphrey</i>		7557 ADDRESS <i>Bethesda, Md</i>		25a. RECD BY REGISTRAR DATE <i>JUL 24 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles J. ...</i>				

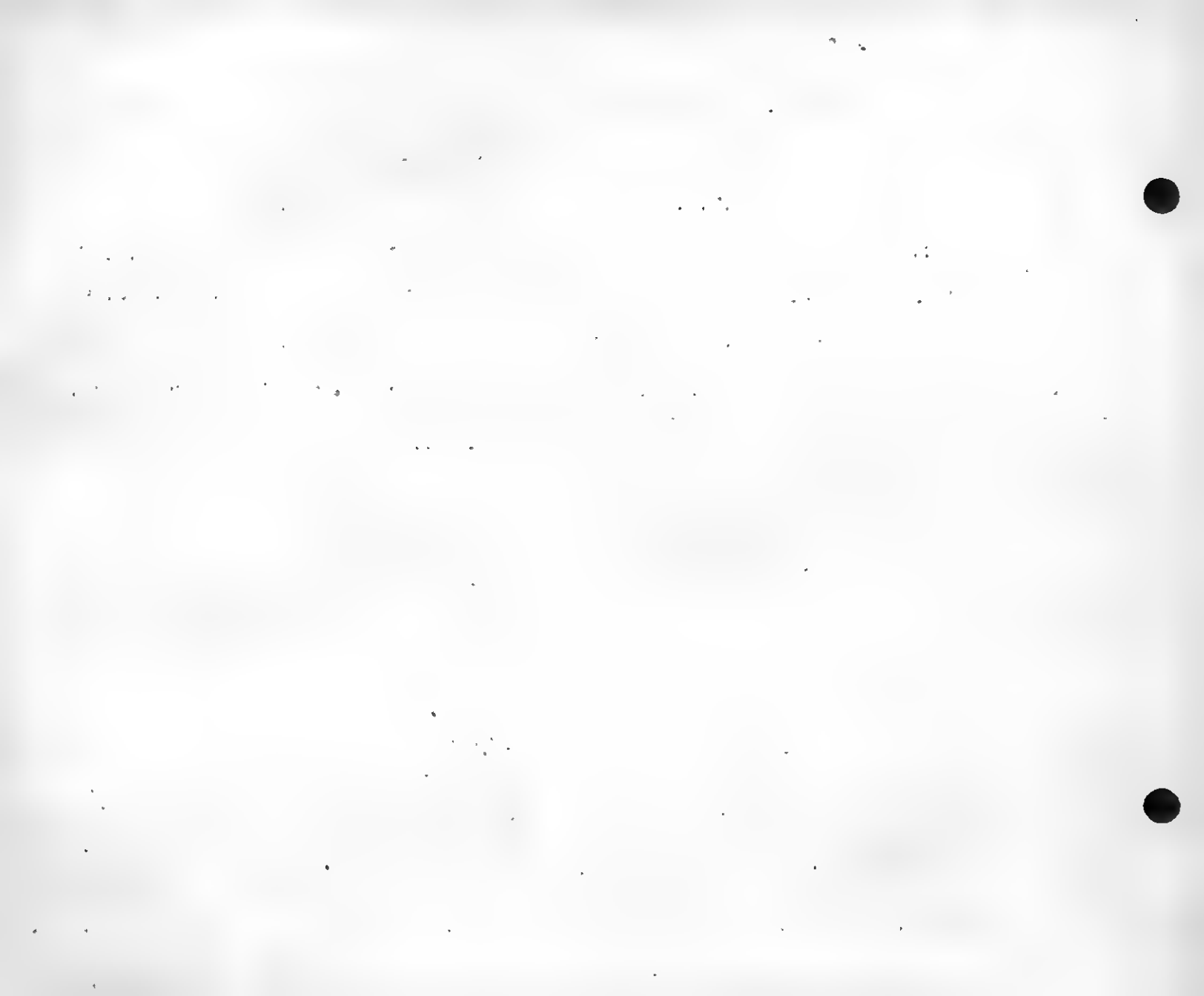


MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print) First Middle Last Alverda Glenoka Nine Stalnaker			2a DATE OF DEATH Month Day Year July 21 1968		2b. HOUR M 10
3. SEX F	4. RACE W		5. DATE OF BIRTH May 7, 1894		6. AGE (In years last birthday) 74 YRS.
7a BIRTHPLACE (State or foreign country) West Va.		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
9 COUNTY OF DEATH Montgomery			10. CITY OR TOWN OF DEATH Gaithersburg		
11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Asbury Methodist Home			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Stenographer		12b KIND OF BUSINESS OR INDUSTRY U.S. Gov't
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE District of Columbia		13b. COUNTY Washington		13c. CITY OR TOWN Washington	
13d. RESIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 2150 Penn. Ave., N. W.			
14 FATHER'S NAME First Middle Last Charles W. Nine			15. MOTHER'S MAIDEN NAME First Middle Last Elizabeth Shafer		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no		16b SOCIAL SECURITY NO. 236-14-3920		17. INFORMANT Address Asbury Methodist Home, Gaithersburg, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Pneumonia DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 DAYS					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Generalized arteriosclerosis					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21b. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from 5/2/63 19, to 7/21/68 19, that (I) (we) last saw the deceased alive on 7/19/68 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Henry C. Scruggs MD		22c. DATE SIGNED 7/21/68		22d. PHYSICIAN'S NAME (Type) Henry C. Scruggs MD	
22e. ADDRESS 5413 Cedar Lane Bethesda Md					
23a BURIAL, CREMAT ON, REMOVAL (Specify) Burial		23b DATE July 24, 1968		23c. NAME OF CEMETERY OR CREMATORY Maplewood Cemetery	
23d LOCATION (City or Town) (County) (State) Elkins, Randolph, W. Va.					
24 FUNERAL DIRECTOR Ernest C. Gortner		25a. REC'D BY REGISTRAR DATE JUL 29 1968		25b REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

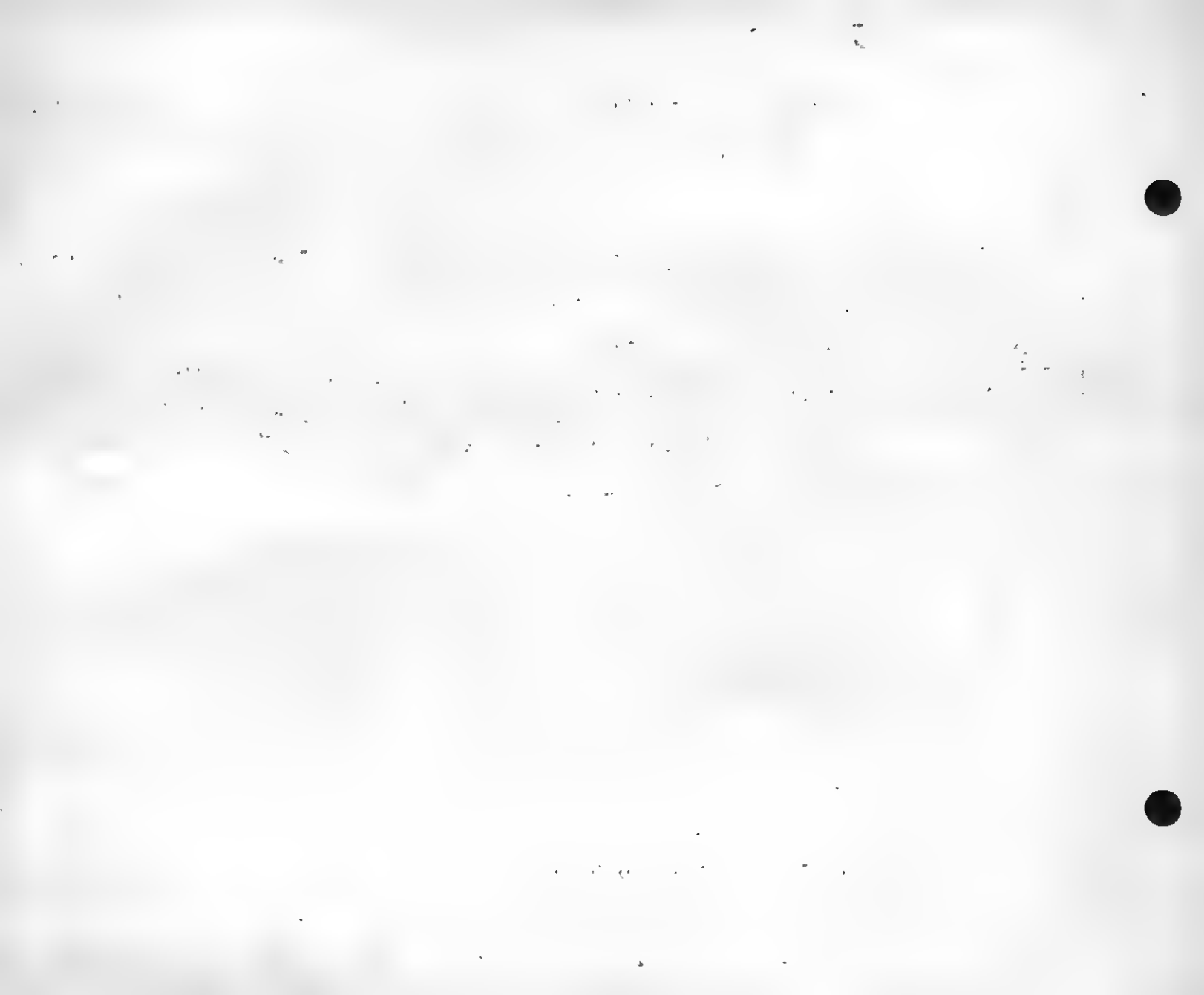
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1 DECEASED-NAME (Type or print)			First Middle Last			2a DATE OF DEATH		2b HOUR		
Paul Bernard Stein						Month Day Year July 15 1968		1:07 P M		
3 SEX		4. RACE		5 DATE OF BIRTH		6 AGE (in years last birthday)		F UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
Male		White		January 14, 1935		33 YRS.				
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Illinois		USA				Montgomery County.		Md.		
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY				
Bethesda		The Clinical Center, NIH		School Teacher		County Govt.				
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE		13b. COUNTY		13c CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER		
Illinois		✓		Murphysboro		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		2015 Walnut Street		
14. FATHER'S NAME			First Middle Last			15. MOTHER'S MAIDEN NAME			First Middle Last	
George Stein						Fern O'Neal				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO		17 INFORMANT					
Yes			Korean		The Medical Record, Clinical Center, National Institutes of Health, Bethesda, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) artery, left common iliac artery, and kidneys									days	
DUE TO, OR AS A CONSEQUENCE OF (b) Hypertrophic subaortic stenosis									years	
DUE TO, OR AS A CONSEQUENCE OF (c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY?		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
					YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		Yes			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC		21f LOCATION		Street or R.F.D. No		City or Town County State		
22a. I certify that (X) (this hospital) attended the deceased from June 23, 19 68, to July 15, 19 68, that (X) (we) last saw the deceased alive on July 15, 19 68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death.										
22b SIGNATURE					DEGREE		ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED	
H. Bryan Brewer, Jr., M. D.									16 July 1968	
22d. PHYSICIAN'S NAME (Type)		23a. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town)		(County)		(State)	
H. Bryan Brewer, Jr., M. D.		AVA EVERGREEN CEM			AVA				MD	
23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		23e. REC'D BY REGISTRAR		23f. REGISTRAR'S SIGNATURE		
7-18-68		AVA EVERGREEN CEM		AVA		JUL 17 1968		Charles Judge		
24. FUNERAL DIRECTOR		24. FUNERAL DIRECTOR		24. FUNERAL DIRECTOR		24. FUNERAL DIRECTOR		24. FUNERAL DIRECTOR		
W.W. Chambers		W.W. Chambers		W.W. Chambers		W.W. Chambers		W.W. Chambers		



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR ATSMF (5)
10M REV 1/68

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1 DECEASED-NAME (Type or Print)			First	Middle	Last	2a DATE KNOWN OF DEATH			2b HOUR
Deborah Anne Steinberg						Month Day Year			12 P.M.
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN	2c DATE PRONOUNCED DEAD			2d HOUR
Female	White	5/5/68	YRS 2	MONTHS 7	HOURS	Month Day Year			12:15 P.M.
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			P.M.
Washington DC		U.S.A.				Montgomery			MD
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY	
Bethesda		Suburban			none				
13a USUAL RESIDENCE (Where deceased lived, if institution on admission) STATE			13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS?		13e STREET AND NUMBER
Md.			Montgomery		Silver Spring		YES <input type="checkbox"/> NO <input type="checkbox"/>		555 Thayer Avenue
14 FATHER'S NAME			First	Middle	Last	15 MOTHER'S MAIDEN NAME			First Middle Last
Michael Steinberg						Bonnie Acker			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SECURITY NO		17. INFORMANT ADDRESS				
					Michael Steinberg - Father				
18. CAUSE OF DEATH (Enter on only one cause per line for (a), (b) and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Anoxia -</u>									<u>4 hr.</u>
911X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Aspiration of Gastric Contents.</u>									
(c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
<u>1-112</u>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20 AUTOPSY?			
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b TIME OF INJURY Month, Day, Year		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
		8:50 P.M. 7/12/68		Aspirated Vomited Milk					
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc)		21f LOCATION Street or RFD No		City or Town		County	State
		in car		Potomac		Montgomery		MD	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE		John G. Ball		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED	
EXAMINER'S NAME (Type)		John G. Ball				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		12 July 68	
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
						ADDRESS (Street, city, town, or county)			
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town)		County	State
		7/12/68		Washington Hebrew Cong. Cem.		Washington D.C.			
24 FUNERAL DIRECTOR		25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE		DATE			
Baruch Danyonky, 4800 N. 750 14th St. N.W.		JUL 17 1968		John G. Judge					



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 18-22a Film 403 Maryland State Department of Health
8-1-68 ams DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED NAME (Type or Print) JAMES EDWARD STEWART						2a. DATE OF DEATH 7-20		2b. HOUR 11:30	
3. SEX MALE	4. RACE CAUCASION	5. DATE OF BIRTH 8-20-33	6. AGE (In years as birthday) 34 YRS	IF UNDER 1 YEAR MONTHS 0 DAYS 0 HOURS 0 MIN	2c. DATE PRONOUNCED DEAD Month 7 Day 20 Year 1968		2d. HOUR 11:30		
7a. BIRTHPLACE (State or foreign country) PENNSYLVANIA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH MONTGOMERY Md			
10. CITY OR TOWN OF DEATH TAKOMA PARK		11. NAME OF HOSPITAL, OR INSTITUTION (If not an hospital give street address) WASHINGTON SAN & HOSPITAL			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) INSULATION ENGINEER		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MD.			13b. COUNTY GERMANTOWN		13c. CITY OR TOWN YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER Rt/ 2 BURDETTE LANE		
14. FATHER'S NAME First Middle Last LAWRENCE W. STEWARD				15. MOTHER'S MAIDEN NAME First Middle Last AMANDA MAE KOFFMAN					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) YES			16b. SOCIAL SECURITY NO 51-159		17. INFORMANT HOSPITAL RECORD				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pulmonary embolism secondary DUE TO, OR AS A CONSEQUENCE OF (b) to broken neck incurred while DUE TO, OR AS A CONSEQUENCE OF (c) diving in pool								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) None									
19a. DATE OF OPERATION 7/24		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED neck.				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day Year 600 P.M. 7/4 1968		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) Deceased dove into shallow pool & broke					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Pool		21f. LOCATION Street or R.F.D. No -		City or Town Montg. County Md. State			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE Richard R. Reap		22b. DATE SIGNED July 20, 1968		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
EXAMINER'S NAME (Type) Richard R. Reap		ADDRESS (Street, Apt. No., P.O. Box, or country)							
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		23b. DATE 24 July 1968		23c. NAME OF CEMETERY OR CREMATORY PARKLAWN CEMETERY		23d. LOCATION (City or Town) (County) (State) SILVER SPRING MD.			
24. FUNERAL DIRECTOR FINLAND FUNERAL HOME Inc		ADDRESS 7400 GEORGIA AVE NW		25a. RECD BY REGISTRAR DATE JUL 25 1968		25b. REGISTRAR'S SIGNATURE Charles J. J...			



CERTIFICATE OF DEATH

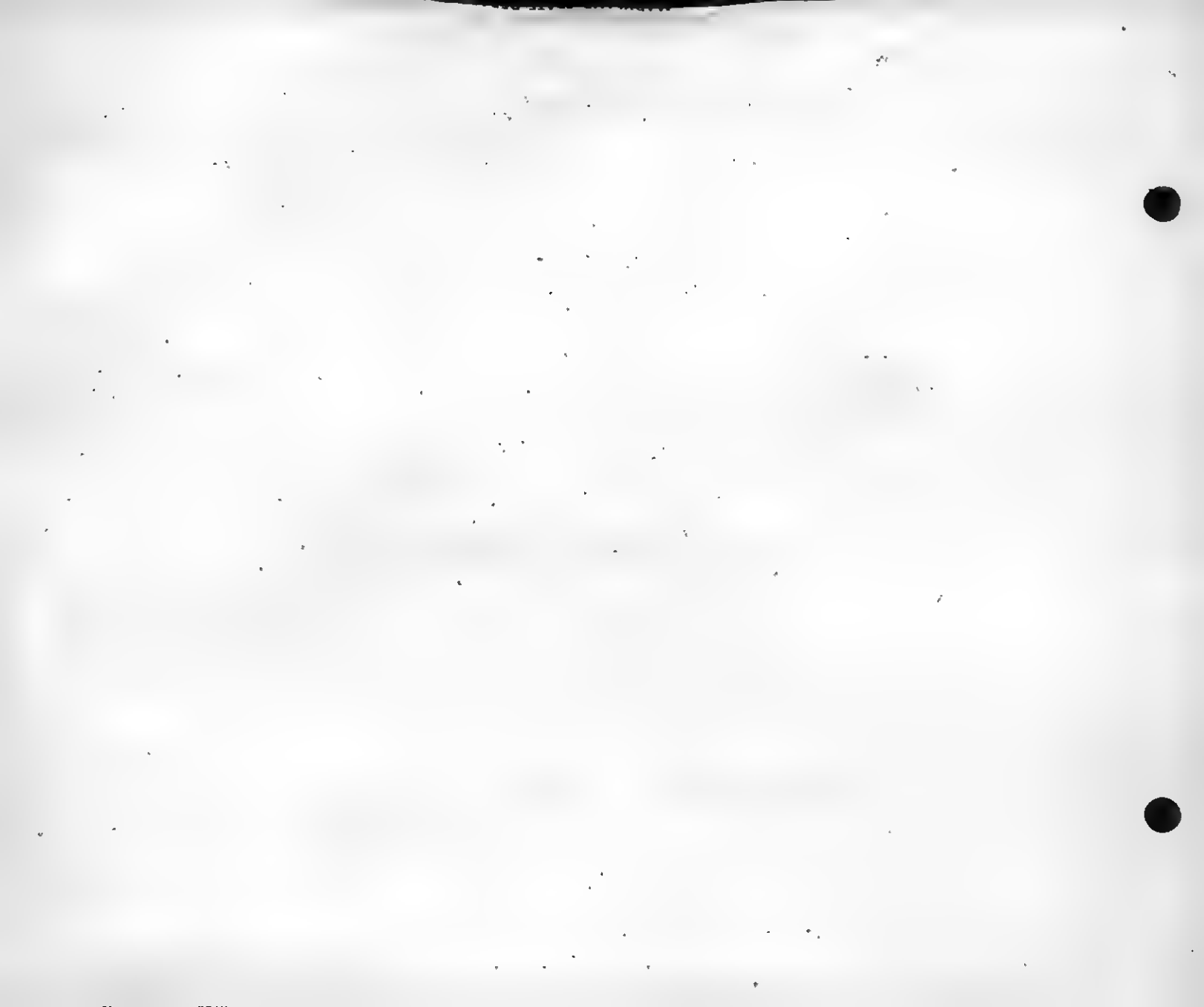
100861

10071

1. DECEASED NAME (Type or print) <i>Margaret Marie Stoker</i>			2a. DATE OF DEATH Month <i>July</i> Day <i>8</i> Year <i>1968</i>		2b. HOUR <i>10:30 P.M.</i>
3 SEX <i>Female</i>	4 RACE <i>White</i>	5. DATE OF BIRTH <i>12-7-1895</i>		6 AGE (In years lost birthday) <i>72 YRS</i>	IF UNDER 1 YEAR MONTHS DAYS
7a. BIRTHPLACE (State or foreign country) <i>Germany</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. COUNTY OF DEATH <i>Montgomery</i>		Md.			
10. CITY OR TOWN OF DEATH <i>Bethesda</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Retired Homemaker</i>	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <i>Maryland</i>		13b. COUNTY <i>Montgomery</i>	13c. CITY OR TOWN <i>Gaithersburg</i>	13d. INSIDE CITY (Lot 1st) YES <input type="checkbox"/> NO <input type="checkbox"/>	3e. STREET AND NUMBER <i>501 South Frederick Ave</i>
14. FATHER'S NAME First <i>Frank</i> Middle <i>Stoker</i> Last <i>Stoker</i>		15. MOTHER'S MAIDEN NAME First <i>Anna</i> Middle <i>Brunde</i> Last <i>Brunde</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, (no, (unknown) <i>No</i> (If yes give year or dates of service) <i>No</i>		16b. SOCIAL SECURITY NO. <i>-</i>		17. INFORMANT <i>Wayne Robel, Son-in-Law, 114 Confield</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Emoxia</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Pulmonary Embolus</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Myocardial Infarction</i>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>12 hours</i> <i>5 days</i>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Diabetes Mellitus, Renal Failure, Infection</i>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <i>July 3, 1968</i> , to <i>July 8, 1968</i> , that (I) (we) lost saw the deceased alive on <i>July 8, 1968</i> and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>STEVEN CONWAY MD</i>		DEGREE <i>MD</i>		22c. DATE/SIGNED <i>July 9, 1968</i>	
22d. PHYSICIAN'S NAME (Type or print) <i>STEVEN CONWAY MD</i>		22e. ADDRESS <i>570 No FREDERICK</i>		22f. CITY/TOWN/STATE <i>GAITHERSBURG, Md</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>7-12-1968</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Grand View Cemetery</i>	
23d. LOCATION (City or Town) <i>Cambria, Penna.</i>		(County) <i>Md</i>		(State) <i>Md</i>	
24. FUNERAL DIRECTOR <i>Joseph Gawler's Sons, Inc., 5130 Wisc. Ave. Wash., D.C., 20016</i>		ADDRESS <i>5130 Wisc. Ave.</i>		25a. RECD BY REGISTRAR <i>JUL 10 1968</i>	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) <i>Last First</i> STRALEY, MICHAEL DEVAUX STRALEY		2a. DATE OF DEATH Month JULY Day 5 Year 68		2b. HOUR 1:45 PM
3 SEX MALE	4. RACE CAUC	5. DATE OF BIRTH 28 JUNE 1968	6. AGE (In years last birthday) YRS. 7	IF UNDER 1 YEAR MONTHS 7 DAYS 7
7a. BIRTHPLACE (State or foreign country) MD	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH MONTGOMERY	
10. CITY OR TOWN OF DEATH BETHESDA	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) NAVAL HOSPITAL	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) - STATE BETHESDA	13b. COUNTY MONTGOMERY	13c. CITY OR TOWN BETHESDA MD	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER NAVAL HOSPITAL
14. FATHER'S NAME First Middle Last RICHARD P. STRALEY		15. MOTHER'S MAIDEN NAME First Middle Last JEANNE ANN GOODWIN		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT RICHARD P. STRALEY, 6394 WINGATE ST		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) PREMATURE MALE INFANT 675 GRAMS DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)				
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	21e. PLACE OF INJURY (AT HOME FARM STREET FACTORY OFFICE BUILDING ETC)	21f. LOCATION Street or R.F.D. No	City or Town	County State
22a. I certify that he (this hospital) attended the deceased from 28 JUNE , 19 68 , to 5 JULY , 19 68 , that he (we) last saw the deceased alive on 5 JULY , 19 68 and that in my (our) opinion death occurred on the date and hour and from the causes stated above, he (we) (d) (did not) view the body after death.				
22b. SIGNATURE <i>J. J. Tomaso</i>		DEGREE MD	ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>	22c. DATE SIGNED 7 JULY 1968
22d. PHYSICIAN'S NAME (Type) DR. J. J. TOMASOVIC, MC, USAF		22e. ADDRESS NAVAL HOSPITAL, BETHESDA MD		
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	23b. DATE 7-8-68	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill	23d. LOCATION (City or Town) (County) (State) Suitland, Md.	
24. FUNERAL DIRECTOR Robert A. PUMPHREY		25a. REC'D BY REGISTRAR JUL 11 1968	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	
26. ADDRESS 7557 Wisconsin Ave., Bethesda, Md.				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1 DECEASED-NAME (Type or print)			First	Middle	Last	2a DATE OF DEATH		2b HOUR	
MARY				CANTRELL	STOTLAR	Month 7 Day 1 Year 68		12:28 PM	
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (in years lost birthday)		7 IF UNDER 1 YEAR MONTHS DAYS	
F		Cau.		7 June 1885		83 YRS.			
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.	
Ill.		U. S.				Montgomery			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUA. OCCUPATION (Kind of work done during most of working life, even if retired.)		12b KIND OF BUSINESS OR INDUSTRY	
Rockville			Browner Lane Nursing Home			Salesman			
13a USUAL RESIDENCE (Where deceased lived, if inst. tition. Residence before admn. ssion) STATE			13b COUNTY			13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
9316 W. Parkhill Dr.			Montgomery			Baltimore		9316 W. Parkhill Dr.	
14 FATHER'S NAME			First	Middle	Last	15 MOTHER'S MAIDEN NAME			First
Wm. S. Cantrell						Jenny Burnett			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)			16b SOCIAL SECURITY NO			17 INFORMANT			Address
			361-29-7051A			JAMES C. STOTLAR, SON.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease									15 yrs.
DUE TO, OR AS A CONSEQUENCE OF									
(b) Generalized Arteriosclerosis									
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
Left Hemiplegia									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC)			21f. LOCATION Street or R.F.D. No		City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from June 29, 1968 to July 1, 1968, that (I) (we) last saw the deceased alive on June 29, 1968 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.									
22b. SIGNATURE			22c. DATE SIGNED						
John R. Ewan MD			7-1-68						
22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS						
John Ewan, M.D.			916 19th St. N.W., Wash., D.C.						
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
Burial - Rem.			7-2-1968		Benton Cemetery		Benton, Ill.		
24. FUNERAL DIRECTOR			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE			
Joseph Gawler's Sons, Inc., 5130 Wisc. Ave. N.W., Wash., D.C., 20016			JUL - 5 1968			J. Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transcript permit. Then please remove carbon papers - Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED NAME (Type or print) Jerr Wayne STURCILL II					2a. DATE OF DEATH JULY Month 27 Day 69 Year		2b. HOUR 6:35 P M		
3. SEX Male		4. RACE Caucasion		5. DATE OF BIRTH 16 JUNE 68		6. AGE (In years lost birthday) YRS 1 MONTHS 11 DAYS		IF UNDER 1 YEAR IF UNDER 24 HRS	
7a. BIRTHPLACE (State or foreign country) SPAIN		7b. CITIZEN OF WHAT COUNTRY? UNITED STATES		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH MONTGOMERY			
10. CITY OR TOWN OF DEATH BETHESDA			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) NAVAL HOSPITAL			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE OHIO			13b. CITY OR TOWN JACKSON		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET AND NUMBER 21 PUTMAN STREET		
14. FATHER'S NAME JERRY WAYNE STURGILL I			15. MOTHER'S MAIDEN NAME CAROL JEAN HOWELL						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16b. SOCIAL SECURITY NO. NONE		17. INFORMANT JERRY WAYNE STURGILL I		Address SAGE AS 13 ABC		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGENITAL HEART DISEASE									
1469 DUE TO, OR AS A CONSEQUENCE OF TRICUSPID ATRESIA									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.									
DUE TO, OR AS A CONSEQUENCE OF (b)									
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
7545									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (X) (this hospital) attended the deceased from 26 JULY , 19 68 , to 27 JULY , 19 68 , that (X) (we) last saw the deceased alive on 27 JULY , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (d) (did not) view the body after death.									
22b. SIGNATURE <i>H.E. Ashworth</i>					DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 28 JULY 68		
22d. PHYSICIAN'S NAME (Type) H.E. ASHWORTH M.D.					22e. ADDRESS NAVAL HOSPITAL, BETHESDA, MARYLAND				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 7-31-1968		23c. NAME OF CEMETERY OR CREMATORY FAIRMOUNT CEM.		23d. LOCATION (City or Town) (County) (State) JACKSON - JACKSON OHIO			
24. FUNERAL DIRECTOR <i>W. H. Chambers Co. 1400 14th St. N.W. Washington D.C.</i>					25a. REC'D BY REGISTRAR DATE JUL 31 1968		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 12 hours after death.

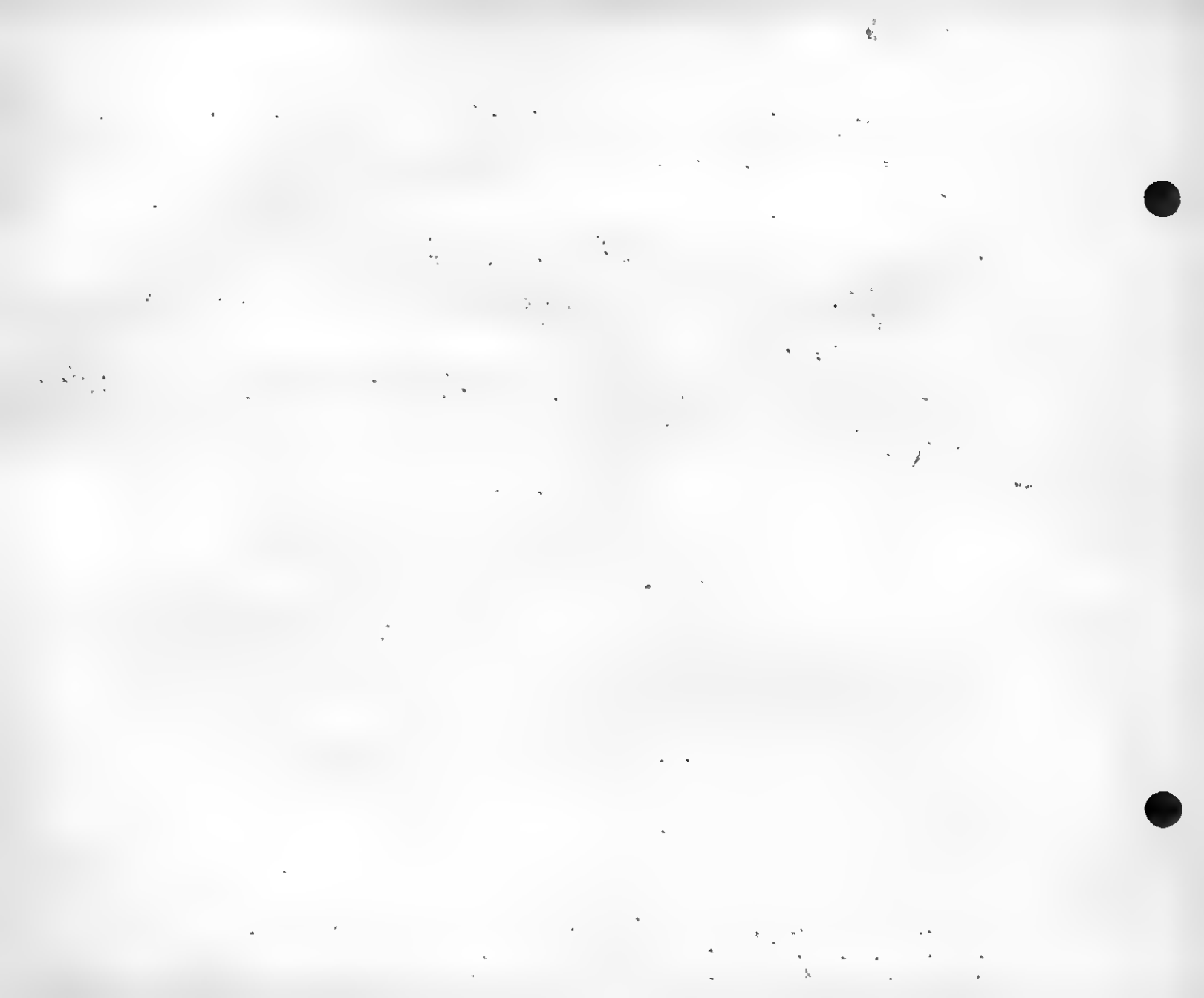
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2063

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) <i>Sylvia</i>		Middle <i>Such</i>		Last <i>Such</i>		2a. DATE OF DEATH Month <i>July</i> Day <i>31</i> Year <i>1968</i>		2b HOUR- M <i>2 P.</i>	
3 SEX <i>Female</i>		4. RACE <i>White</i>		5 DATE OF BIRTH <i>Feb. 1872</i>		6 AGE (in years last birthday) <i>96</i> YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a BIRTHPLACE (State or foreign country) <i>N. J.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <i>Montgomery</i>		Md.	
10 CITY OR TOWN OF DEATH <i>Wren</i>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Sharon Nursing Home</i>		12a USUAL OCCUPATION (Kind of work done during most of work ng life, even if retired) <i>Homemaker</i>		12b KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>			
13a USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) <i>Box 55, Roselle N.J.</i>		13b COUNTY <i>New Jersey</i>		13c CITY OR TOWN <i>Roselle</i>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER <i>Box 55, Roselle</i>	
14. FATHER'S NAME First <i>George</i> Middle <i>Such</i> Last <i>Such</i>		15. MOTHER'S MAIDEN NAME First <i>Anna</i> Middle <i>Ridgeway</i> Last <i>Ridgeway</i>		16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, (no, or unknown) <i>No</i>		16b. SOCIAL SECURITY NO. <i>106-38-2426</i>		17 INFORMANT <i>Henry S. Smith Box 55, Roselle N.J.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>Peckeria</i> <i>-700</i> DUE TO, OR AS A CONSEQUENCE OF <i>Chronic pyelonephritis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <i>700</i> (b) <i>Chronic pyelonephritis</i> DUE TO, OR AS A CONSEQUENCE OF <i>700</i> (c) <i>700</i>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 yr 5</i>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>6000 Schizophrenia</i>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f LOCATION Street or R.F.D. No. City or Town County State					
22a I certify that (I) (this hospital) attended the deceased from <i>12/11</i> , 19 <i>65</i> , to <i>7/31</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>5/29</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE <i>C. H. Hughes</i>		DEGREE <i>MD</i>		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>7/31/68</i>			
22d. PHYSICIAN'S NAME (Type) <i>C. H. Hughes MD</i>		22e ADDRESS <i>Sandy Spring Md, 20860</i>							
23a. BURIAL, CREMATION, REMOVAL, ETC. <i>Funeral Home</i>		23b DATE <i>Aug. 2, 1968</i>		23c NAME OF CEMETERY OR CREMATORY <i>Christ Church Cemetery</i>		23d LOCATION (City or Town) (County) (State) <i>South Ambou, New Jersey</i>			
23e. FUNERAL DIRECTOR <i>Warner E. Pumphrey, Inc.</i>		23f ADDRESS <i>4334 Georgia Ave.</i>		23g CITY <i>Silver Spring, Md.</i>		25a. REC'D BY REGISTRAR DATE <i>AUG 5 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

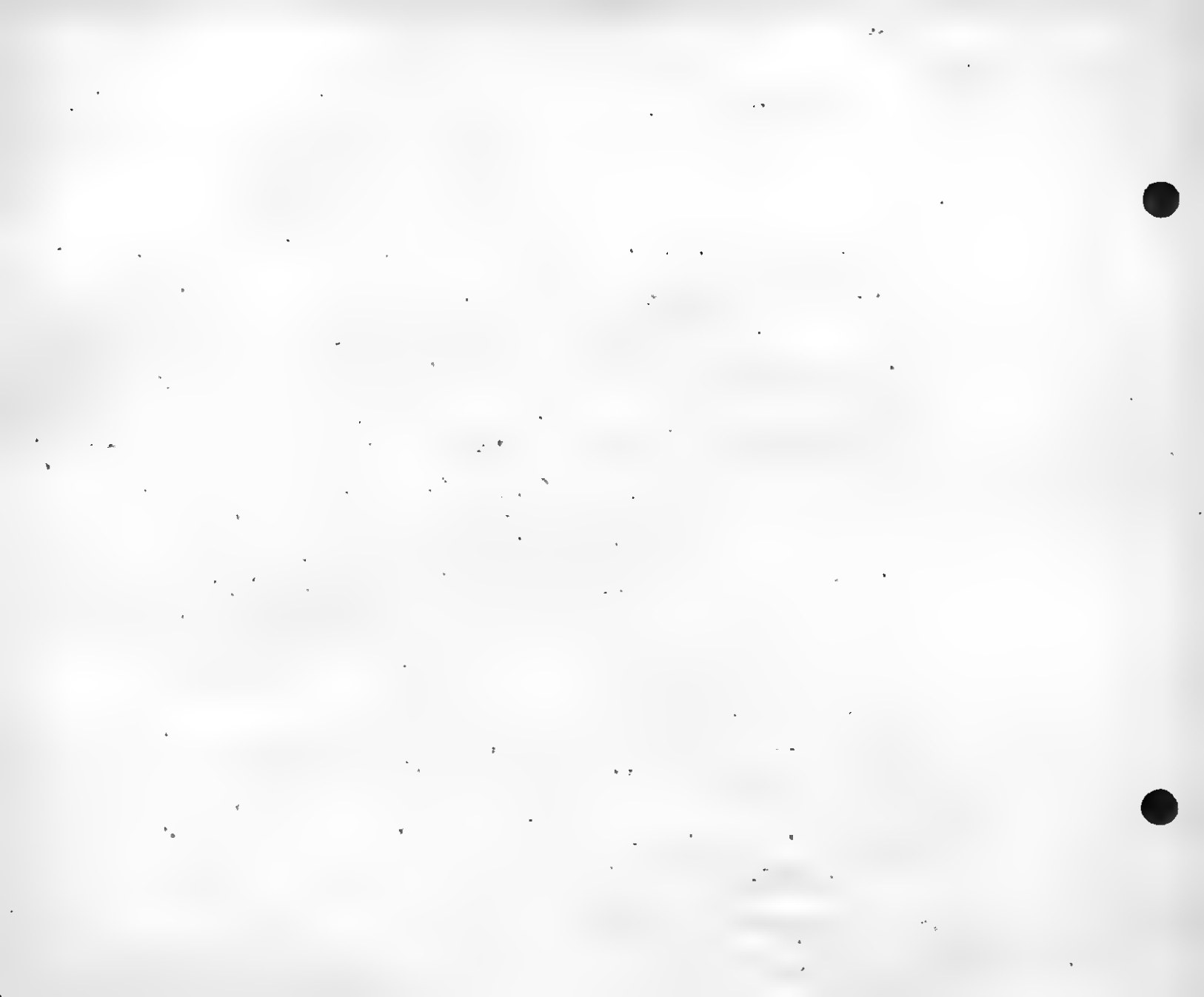


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print) FRANCES EDNA SUTER			2a. DATE OF DEATH Month JULY Day 1 Year 1968			2b. HOUR 6:00 M	
3 SEX FEMALE		4 RACE WHITE		5 DATE OF BIRTH FEB. 22. 1879		6 AGE (In years last birthday) 89 YRS	
7a. BIRTHPLACE (State or foreign country) WASH. D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery	
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Colonial Villa		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY at Home	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MD		13b. COUNTY Mont.		13c. CITY OR TOWN Takoma Park		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 7667 Maple Avenue		14 FATHER'S NAME First Henry Middle H. Last Hough		15. MOTHER'S MAIDEN NAME First Thurza Middle Frances Last Johnson			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b. SOCIAL SECURITY NO.		17. INFORMANT Mrs. WM H. Parsons		Address 10535 Sweetbrier Pkwy	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Cardiac Failure							2 days
DUE TO, OR AS A CONSEQUENCE OF (b) Cardio-Vascular-Renal Syndrome (chronic)							
DUE TO, OR AS A CONSEQUENCE OF (c) Advanced age							Sev. yrs
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Arthritis of spine (lumbar); Riverticulis							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Jan Day 19 Year 1968		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from Jan. 1968 , to July 1, 1968 , that (I) (we) last saw the deceased alive on June 30, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.							
22b. SIGNATURE Lynwood Heiges MD		22c. PHYSICIAN'S NAME (Type) LYNWOOD HEIGES		22d. ADDRESS 15015 Flower Valley Court		22e. DATE SIGNED July 1, 1968	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE July 5, 1968		23c. NAME OF CEMETERY OR CREMATORY Greenwood Cemetery		23d. LOCATION (City or town) (County) (State) Washington D.C.	
24. FUNERAL DIRECTOR J. Arthur Walters		ADDRESS 254 Carroll St NW		25a. RECD BY REGISTRAR DAUL - 5 1968		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

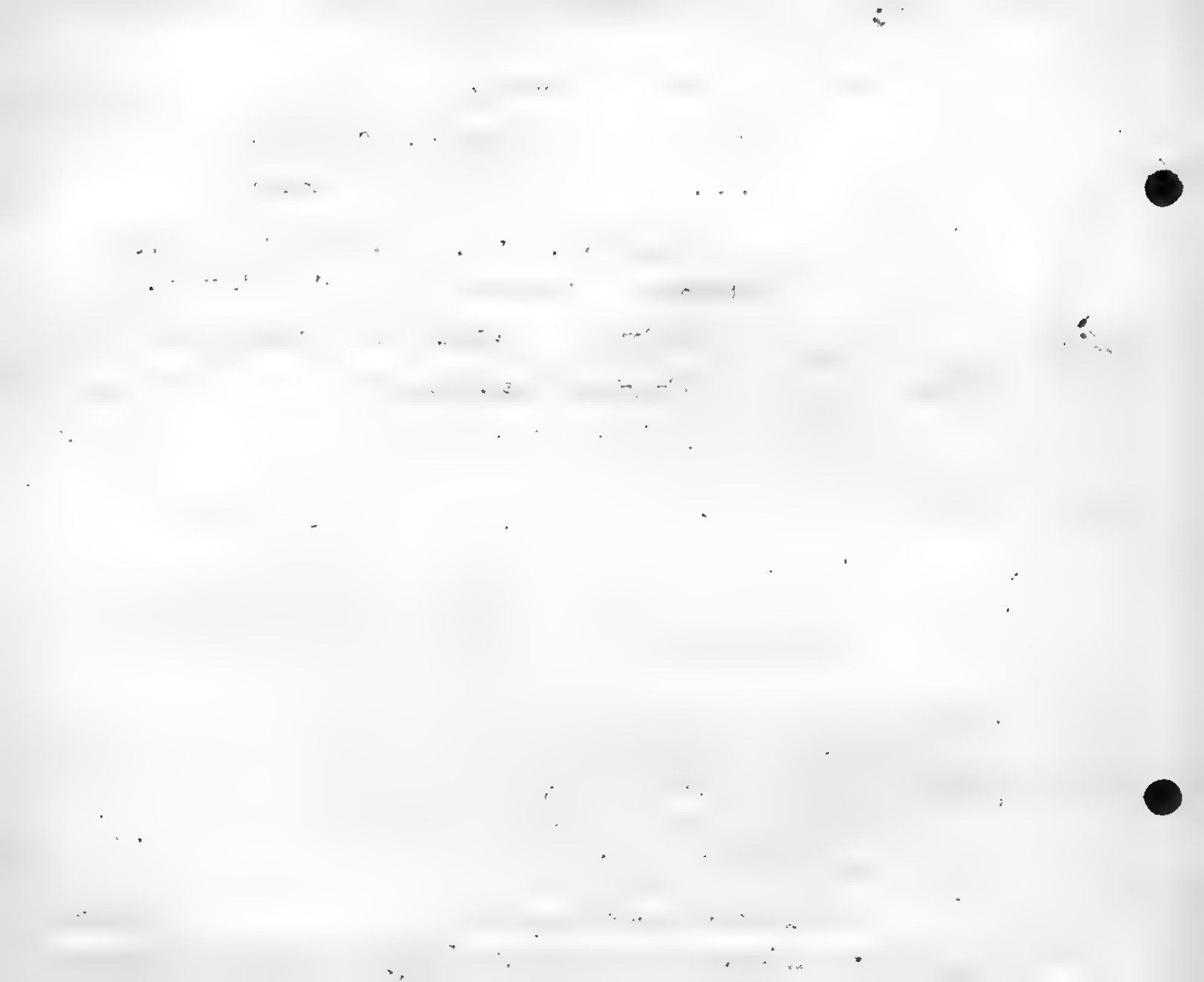


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cleaned by Mr. Ball

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED NAME (Type or print) John Frank Swafford						2a. DATE OF DEATH July 1, 1968			2b. HOUR 2:10 AM		
3. SEX Male		4. RACE White		5. DATE OF BIRTH June 26, 1904/1905		6. AGE (In years last birthday) 63 YRS.		7. UNDER YEAR MONTHS DAYS		8. UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Georgia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery			Md.		
10. CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington San. & Hosp.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Pa. Railroad		12b. KIND OF BUSINESS OR INDUSTRY Retired					
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Takoma Park		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 7130 Willow Ave.			
14. FATHER'S NAME First James Middle Swafford Last Swafford				15. MOTHER'S MAIDEN NAME First MAMIE Middle Mary Last Frances Ramie							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) None		16b. SOCIAL SECURITY NO. 219-01-2929		17. INFORMANT Address Hosp. Record							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 1929 (b) Cachexia DUE TO, OR AS A CONSEQUENCE OF (c) Osteosarcoma Grade III										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days 6 mos 3 yrs	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Osteoarthritis											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, not by medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home farm street factory) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (his hospital) attended the deceased from 9-13 , 19 67 , to 6-28 , 19 68 , that (I) (we) last saw the deceased alive on 6-28 , 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE John L. Ford		DEGREE MD		ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 7-1-68			
22d. PHYSICIAN'S NAME (Type) JOHN L. FORD		22e. ADDRESS 831 UNIVERSITY BLVD. SILVER SPRING, MD.									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE July 3-1968		23c. NAME OF CEMETERY OR CREMATORY Bethany		23d. LOCATION (City or Town) (County) (State) Bethesda Montgomery Maryland					
24. FUNERAL DIRECTOR John H. Waters		ADDRESS 254 Carroll St		25a. REC'D BY REGISTRAR DATE 7-5-1968		25b. REGISTRAR'S SIGNATURE Charles Judge					



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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1 DECEASED NAME (Type or print) Ellamae			First Middle Last (NMN) Tate		2a DATE OF DEATH Month July Day 31 Year 1968			2b HOUR A M 5:50 M	
3 SEX Female		4 RACE Negro		5 DATE OF BIRTH October 31, 1930		6 AGE (in years last birthday) 37 YRS.		7 UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a BIRTHPLACE (State or foreign country) Connecticut		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.			
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) The Clinical Center, NIH		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Practical Nurse		12b KIND OF BUSINESS OR INDUSTRY			
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE New York		13b COUNTY		13c CITY OR TOWN New York		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 229 West 110th Street	
14 FATHER'S NAME First Middle Last Hasker Tate			15 MOTHER'S MAIDEN NAME First Middle Last Gladys Turner						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No (If yes give war or dates of service)		16b SOCIAL SECURITY NO. Not available		17 INFORMANT The Medical Record Address The Clinical Center, Bethesda, Maryland					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Aspiration 1930 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Metastatic Carcinoma of the Ovary (Lipoid) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 Hour 27 Months									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 1930									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from June 10 , 19 68 , to July 31 , 19 68 , that (I) (we) last saw the deceased alive on July 31 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death.									
22b. SIGNATURE Mark E. Oren, M.D.		DEGREE		ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED 31 July 1968			
22d. PHYSICIAN'S NAME (Type) Mark E. Oren, M. D.		22e. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 8-5-68		23c. NAME OF CEMETERY OR CREMATORY FERNCLIFF CEM.		23d. LOCATION (City or Town) (County) (State) HARTSDALE, N.Y.			
24 FUNERAL DIRECTOR W.W. Chambers Co. Inc.		ADDRESS		25a. REGISTRAR'S SIGNATURE Charles Judge		25b. REGISTRAR'S SIGNATURE Charles Judge			



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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) <i>Robert Thompson</i>			2a. DATE OF DEATH Month <i>July</i> Day <i>30</i> Year <i>1968</i>		2b. HOUR <i>7A</i> M.
3 SEX <i>Male</i>	4. RACE <i>White</i>	5. DATE OF BIRTH <i>1/2/00</i>		6. AGE (In years lost birthday) <i>68</i> YRS.	IF UNDER 1 YEAR MONTHS _____ DAYS _____
7a. BIRTHPLACE (State or foreign country) <i>Md</i>	7b. CIT. ZEN OF WHAT COUNTRY? <i>U.S.A</i>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i> Md.	
10. CITY OR TOWN OF DEATH <i>Bethesda</i>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Retired</i>		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md</i>	13b. COUNTY <i>Mont</i>	13c. CITY OR TOWN <i>Cherry Hill</i>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <i>6701 Melville Place</i>	
14. FATHER'S NAME First Middle Last <i>UNKNOWN</i>		15. MOTHER'S MAIDEN NAME First Middle Last <i>Anna Mahoney</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>NO</i>		16b. SOCIAL SECURITY NO <i>471-07-9993</i>		17. INFORMANT <i>Wife Anita Thompson</i> Address <i>same as above</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebro-vascular accident</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Arteriosclerotic vascular disease</i> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>16 hrs</i>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <i>331X Benign Prostatic Hyperplasia</i>					
19a. DATE OF OPERATION <i>none</i>	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. _____ Month _____ Day _____ Year _____ P.M. _____ 19____	21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State		
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Henry Wise, Jr. MD</i>		DEGREE <i>MD</i>	ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED <i>JULY 68</i>	
22d. PHYSICIAN'S NAME (Type) <i>Henry Wise, Jr.</i>		22e. ADDRESS <i>WILKESVILLE ST, SILVER SPRING</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE <i>7-31-68</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Gate of Heaven Cem.</i>		23d. LOCATION (City or Town) (County) (State) <i>Silver Spring, Maryland</i>	
24. FUNERAL DIRECTOR <i>ROBERT A. PUMPHREY, Bethesda, Maryland</i>			25a. REC'D BY REGISTRAR DATE <i>AUG 5 1968</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) Oswald Newton Todd			2a. DATE OF DEATH Month July Day 3 Year 68			2b. HOUR 11:30 M	
3. SEX M.		4. RACE W		5. DATE OF BIRTH Dec 10 1891		6. AGE (In years last birthday) 76 YRS.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.	
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Barksden Lane Nursing Home		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Retired		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Montgomery		13c. CITY OR TOWN Bethesda		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 4326 Montgomery Ave							
14. FATHER'S NAME First William Middle Newton Last Todd			15. MOTHER'S MAIDEN NAME First Lavinia Middle Jane Last Sheridan				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) Yes		16b. SOCIAL SECURITY NO (If yes give war or dates of service) WW I		17. INFORMANT Brother		17b. ADDRESS Cowdersport, Pa.	
17c. NAME Chester W. Todd							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Prostate with Metastasis 185X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 Months
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 1111							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home farm street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 1960 , to date , 19 68 , that (I) (we) last saw the deceased alive on July 3 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE John G. Ball M.D.		DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED July 3, 1968	
22d. PHYSICIAN'S NAME (Type) JOHN G. BALL		22e. ADDRESS 7936 Old Georgetown Rd. Bethesda, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 7-6-68		23c. NAME OF CEMETERY OR CREMATORY Geo. Washington Mem. Park, Hyattsville, Maryland		23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR Robert A. Pumphrey		ADDRESS 7557 Wisconsin Bethesda		25a. REC'D BY REGISTRAR JUL 11 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED NAME (Type or print) First Middle Last EDWARD J. TOLBERT SR.					2a. DATE OF DEATH Month Day Year July 4 1968			2b. HOUR 12:15 P.M.		
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH 9/2/90		6. AGE (in years last birthday) 77 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) VIRGINIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH MONTGOMERY Md.				
10. CITY OR TOWN OF DEATH BETHESDA			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SUBURBAN			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) DELIVERY		12b. KIND OF BUSINESS OR INDUSTRY STERN'S FURNITURE		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND			13b. COUNTY MONTGOMERY		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 230 HOWARD AVE	
14. FATHER'S NAME First Middle Last RUFUS TOLBERT			15. MOTHER'S MAIDEN NAME First Middle Last FANNY CALDWELL							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) NO			16b. SOCIAL SECURITY NO. 226-32-3286		17. INFORMANT Address IOWA TOLBERT - WIFE					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 2301 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Nephrosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) Diabetes Mellitus								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 mos. 2 mos. 1 yr.		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Gouty Left Leg										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)					
21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at home <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from July 1, 1968 , to July 4, 1968 , that (I) (we) last saw the deceased alive on July 4, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Sidney J. Cohen, M.D. DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>					22c. DATE SIGNED July 4, 1968					
22d. PHYSICIAN'S NAME (Type) Sidney J. Cohen, M.D.					22e. ADDRESS 50 W. Edmonston Pk. Rockville, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial - R.		23b. DATE 7/8/68		23c. NAME OF CEMETERY OR CREMATORY New Dublin		23d. LOCATION (City or Town) (County) (State) New Dublin, Virginia				
24. FUNERAL DIRECTOR Tyson Wheeler Funeral Home-1331 Rockville Pike Rockville, Md.					25a. REC'D BY REGISTRAR JUL - 9 1968		25b. REGISTRAR'S SIGNATURE J. Charles Judge			



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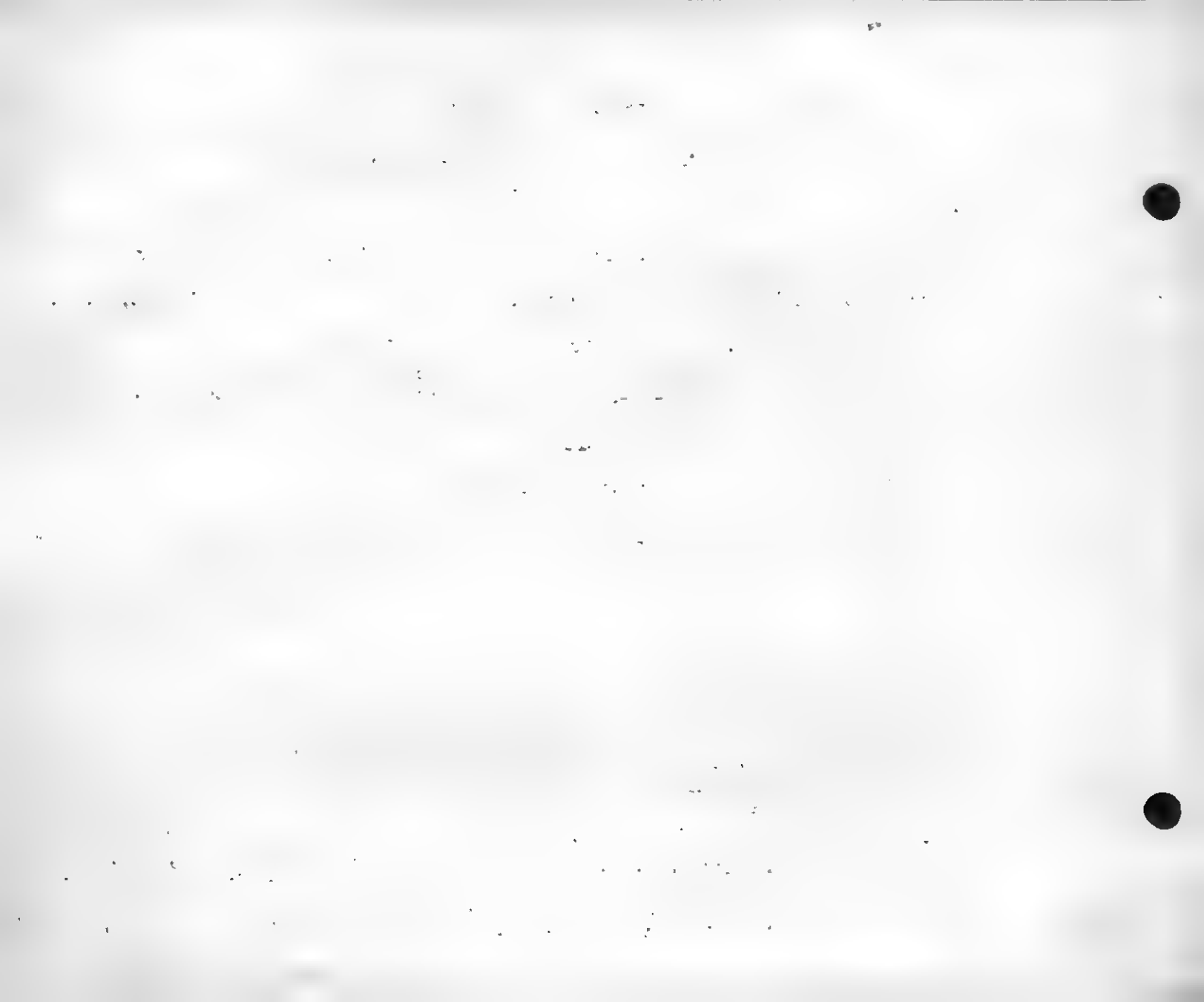
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR	
MAYNARD			A. TOLER			July Month 17 Day Year 68		10 4 M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (in years lost birthday)		7. UNDER YEAR	
Male		White		June 5, 1913		55 YRS.		MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign county)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.	
N. Carolina		U.S.A.				Montgomery			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
Silver Springs			709 Dennis St.			Proprietor		Shoe Store	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
Md.			Montgomery			Silver Sp.		709 Dennis St.	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
Garland			Toler			Bertha		Breeze	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.			17. INFORMANT		Address	
No			577-01-5703			Mrs. Mary B. Toler (Wife)		709 Dennis St.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) CEREBRO-VASCULAR ACCIDENT									
7060 DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost									
(b) HAEMIA									
DUE TO, OR AS A CONSEQUENCE OF									
(c) HYPERTENSION, ESSENTIAL									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
CIRRHOSIS OF LIVER; CHRONIC HEPATITIS									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
				YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
		HOUR A.M. Month Day Year P.M. 19							
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION		Street or R.F.D. No.		City or Town County State	
While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>									
22a. I certify that (1) (this hospital) attended the deceased from 18 JUNE, 1968, to 17 JULY, 1968, that (1) (we) last saw the deceased alive on 12 JULY, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.									
22b. SIGNATURE				DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED	
Eugene J. Chap M.D.								July 17, 1968	
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS					
EUGENE J. CHAP				1302 18th St., N.W., Washington, DC					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		June 20th. 68		Mt. Comfort Cemetery		Alexandria, Virginia			
24. FUNERAL DIRECTOR				ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Ives Funeral Home, 2847 Wilson Blvd, Arl, Va						JUL 22 1968		f Charles Judge	



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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1 DECEASED NAME (Type or print)			First	Middle	Last	2a DATE OF DEATH Month Day Year		2b HOUR AM PM	
David			Forrest	Turner	July 3 1968		5:00		M
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (in years lost, birthday)		IF UNDER 1 YEAR MONTHS DAYS	
Male		Negro		December 15, 1903		64 YRS.			
7a BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Maryland		USA				Montgomery		Md	
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of work no life, even if retired.)		12b KIND OF BUSINESS OR INDUSTRY			
Bethesda		The Clinical Center, NIH		Custodian		Real Estate			
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) - STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER	
District of Columbia				Washington		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		455 15th Street, N. E.	
14 FATHER'S NAME			First	Middle	Last	15 MOTHER'S MAIDEN NAME			First Middle Last
David			H.	Turner	Elizabeth			Johnson	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b SOCIAL SECURITY NO		17. INFORMANT				
No			578-14-6730		The Medical Record Address The Clinical Center, Bethesda, Md. 20014				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) E Coli Septicemia								12 Hours	
DUE TO, OR AS A CONSEQUENCE OF (b) Right Middle Lobe Pneumonia								24 Hours	
DUE TO, OR AS A CONSEQUENCE OF (c) Carcinoma of Stomach								6 Months	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a DATE OF OPERATION									
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED									
20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)									
21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19									
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)									
21d INJURY OCCURRED White <input type="checkbox"/> Not while at work <input type="checkbox"/>									
21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)									
21f LOCATION Street or R.F.D. No. City or Town County State									
22a. I certify that (this hospital) attended the deceased from June 24, 19 68, to July 3, 19 68, that (we) last saw the deceased alive on July 3, 19 68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (do not) view the body after death.									
22b SIGNATURE Robert E. Curran, M. D. ATTENDING PHYS. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>									
22c. DATE SIGNED 3 July 1968									
22d. PHYSICIAN'S NAME (Type) Robert E. Curran, M. D.									
22e. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md.									
23a BURIAL, CREMATION, REMOVAL (Specify)									
23b DATE 8 July 68									
23c NAME OF CEMETERY OR CREMATORY Harmony Nat. Cem.									
23d. LOCATION (City or Town) (County) (State) Landover, Chndes Md.									
24 FUNERAL DIRECTOR									
25a REC'D BY REGISTRAR 25b REGISTRAR'S SIGNATURE									
25c REGISTRAR'S SIGNATURE									



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1 DECEASED NAME (Type or print)			First Middle Last			2a DATE OF DEATH Month Day Year		2b HOUR		
Henderica			A. Vaars			Month 7 Day 14 Year 68		350 P.M.		
3 SEX		4 RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		
Female		Caucasian		12-29-96		71 YRS				
7a BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH				
Holland		U.S.A.				Montgomery County, Md.				
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY		
Silver Spring			Holy Cross Hospital			Housekeeper		AT HOME		
13a. U.S.A. RESIDENCE (Where deceased lived if institution Residence before admission) STATE			13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER	
Md.			Prince Georges		Landover		YES		1400 B Landover Rd.	
14 FATHER'S NAME First Middle Last			15 MOTHER'S MAIDEN NAME First Middle Last							
JACOBUS			BOOT			UNKNOWN				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)			16b SOCIAL SECURITY NO		17. INFORMANT Address					
No			441-32-2832A		JOHANNES VAARS SAME AS (13E)					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4369 DUE TO, OR AS A CONSEQUENCE OF (b) Generalized arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) 331X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 27 hours Unknown		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Arteriosclerotic Heart Disease + Diabetes mellitus										
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f LOCATION Street or R.F.D. No City or Town County State					
22a I certify that (I) (this hospital) attended the deceased from March, 1965, to July 14, 1968, that (I) (we) last saw the deceased alive on July 13, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Aaron H. Trau					22c. DATE SIGNED July 14 1968					
22d. PHYSICIAN'S NAME (Type) W.W. Chambers Co.					22e. ADDRESS 8237 Georgia Ave Silver Spring Md.					
23a BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
CREMATION		7-17-68		FT LINCOLN CREMATORY		BLADENSBURG MD				
24. FUNERAL DIRECTOR W.W. Chambers Co.					25a REC'D BY REGISTRAR DATE JUL 17 1968		25b REGISTRAR'S SIGNATURE Charles Judge			



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18, Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
10M REV 1/68

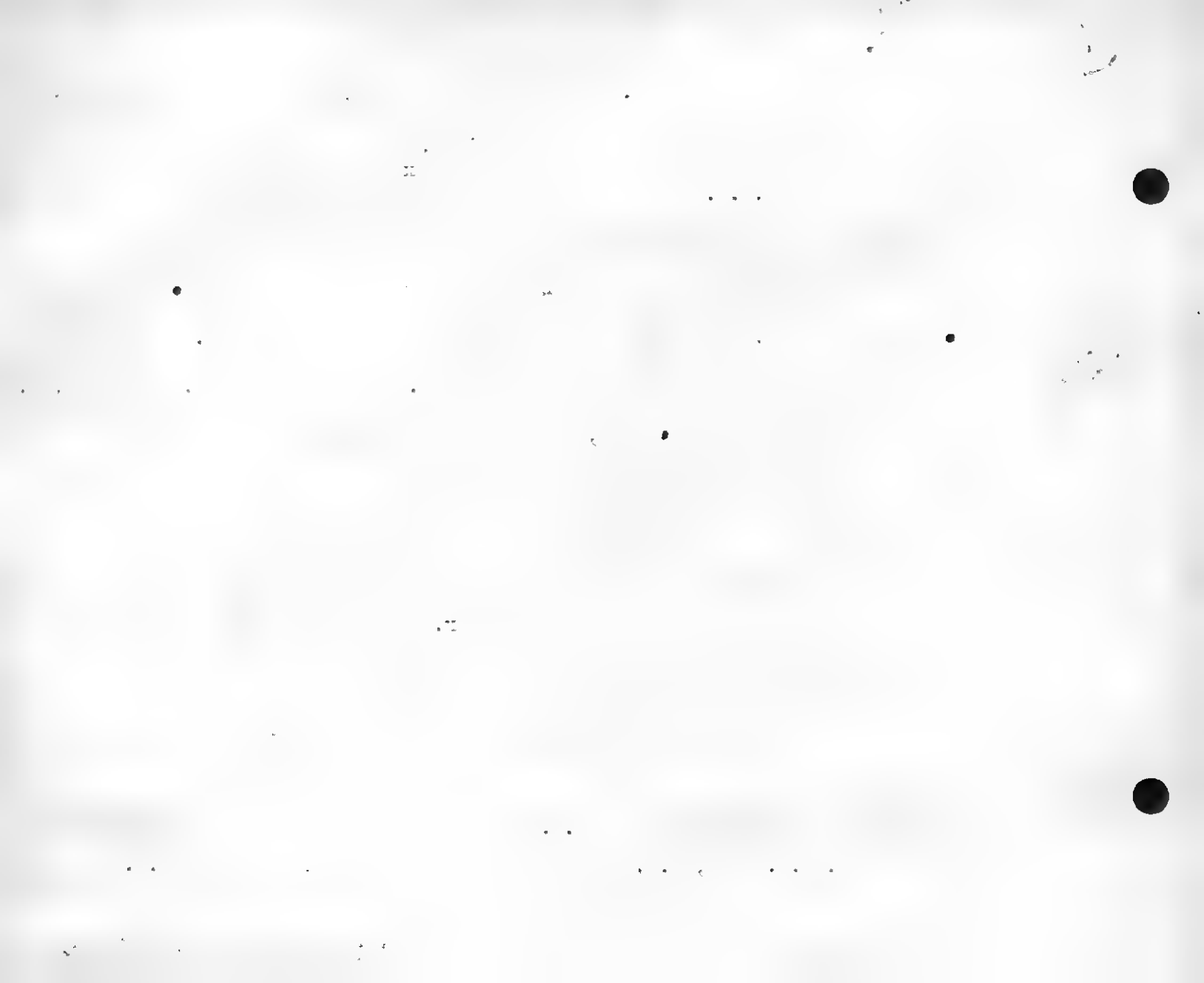
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1 DECEASED NAME (Type or Print)		First		Middle		Last		2a DATE KNOWN OF DEATH		2b HOUR	
Marguerite		J.		Victor				Month Day Year 7-25-1968		P.M.	
3 SEX	4 RACE	5 DATE OF BIRTH		6 AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		2c DATE PRONOUNCED DEAD		2d HOUR
Female	White	Apr. 15, 1901		67 YRS					Month Day Year July 27, 1968		7:30 P.M.
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				Md.	
France		France?				Montgomery					
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY	
Bethesda				8202 Kentbury Drive				Housewife			
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE				13b COUNTY		13c CITY OR TOWN		3d INSIDE CITY, MTS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER	
Maryland				Montgomery		Bethesda				8202 Kentbury Drive	
14 FATHER'S NAME				First		Middle		Last		15 MOTHER'S MAIDEN NAME	
Jean Auguste Chone										Marie Jaquinet	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16b SOCIAL SECURITY NO		17. INFORMANT		ADDRESS			
Yes.				Unknown		French Embassy		Washington, D. C.			
18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Insufficiency, Acute</u> <u>4127</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cardio Vascular Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>Years</u>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>+201 Diabetes Mellitus</u>											
19a. DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b TIME OF INJURY Month, Day Year HOUR A.M. P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or RFD No		City or Town		County		State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE		EXAMINER'S NAME (Type)				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b DATE SIGNED July 27, 1968 ADDRESS (Street, city, town, or county) Bethesda, Maryland			
23a. BURIAL CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town)		(County)		(State)	
Cremation		8-30-68		Cedar Hill Cemetery		Suitland, Maryland					
24 FUNERAL DIRECTOR ADDRESS ROBERT A. PUMPHREY, Bethesda, Maryland						25a REC'D BY REGISTRAR DATE SEP 3 1968		25b REGISTRAR'S SIGNATURE Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1 DECEASED NAME (Type or print)		First Mary		Middle C.		Last VOGT		2a DATE OF DEATH Month 12 Day 1968		2b HOUR 4:55 P
3 SEX Female		4 RACE Caucasian		5 DATE OF BIRTH April 2, 1963		6 AGE (In years last birthday) 5 YRS.		F UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.
7a BIRTHPLACE (State or foreign country) Virginia		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery County Md.				
10 CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Naval Hospital Bethesda		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY				
13a USUAL RESIDENCE (Where deceased admission) STATE Maryland		13b CITY OR TOWN Annapolis		13c INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 1B Adler Road				
14. FATHER'S NAME First Herbert		Middle W.		Last Vogt		15. MOTHER'S MAIDEN NAME First Dolores		Middle L.		Last Miller
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16b SOCIAL SECURITY NO. NONE		17 INFORMANT Herbert W. Vogt		Address 1B Adler Rd. Annapolis, Md.				
18. CAUSE OF DEATH (Enter only one cause per line far (a), (b), and (c))										
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pneumonitis, bilateral, pending physiological findings										
7469 DUE TO, OR AS A CONSEQUENCE OF										
(b) STATUS POST SURGERY										
36 HOURS										
DUE TO, OR AS A CONSEQUENCE OF										
(c)										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
CONGENITAL ANOMALY OF HEART										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, nat'lly medical exam'n'r)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f LOCATION Street or R.F.D. No		City or Town		County State		
22a. I certify that (I) (this hospital) attended the deceased from July 6, 1968, to July 12, 1968, that (I) (we) last saw the deceased alive on July 12, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death										
22b SIGNATURE J.L. Ware		M.D. DEGREE		ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c DATE SIGNED 14 July 68				
22d PHYSICIAN'S NAME (Type) Dr. J.L. WARE, M.D.		22e ADDRESS Naval Hospital, Bethesda, M.D.								
23a BURIAL, CREMATION, OTHER (Specify)		23b DATE 14 JULY 1968		23c NAME OF CEMETERY OR CREMATORY naval hospital cemetery		23d LOCATION (City or Town) (County) (State) ANNAPOLIS MARYLAND				
24 FUNERAL DIRECTOR HARDESTY FUNERAL HOME, ANNAPOLIS MARYLAND		ADDRESS		25a REC'D BY REGISTRAR DATE JUL 17 1968		25b REGISTRAR'S SIGNATURE Charles Judge				



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in permit in item 18. Give Pages 2, 3 and 4 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with permit. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR 1515 (5-51)
10M REV 4-5-68

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. DECEASED NAME (Type or Print) KNOWLES			First Middle Last			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month 7 Day 29 Year 1968			2b. HOUR 6:45 M P
3. SEX M	4. RACE W	5. DATE OF BIRTH 1-1-1877	6. AGE (in years last birthday) 91 YRS	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		2c. DATE PRONOUNCED DEAD 7-29-68 Year 1968 Day 29 Month 7	
7a. BIRTHPLACE (State or foreign country) Kentucky		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.			
10. CITY OR TOWN OF DEATH Kensington		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Kensington Gardens		12a. U.S.A. OCCUPATION (Kind of work done during most of working life, even if retired) Retired		12b. KIND OF BUSINESS OR INDUSTRY Dept of ARG.			
13a. U.S.A. RESIDENCE (Where deceased lived, if institution-Residence before admission) STATE Md			13b. COUNTY Prince George's		13c. CITY OR TOWN Upper Marlboro		13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		13e. STREET AND NUMBER 11101 Belton Street
14. FATHER'S NAME First Middle Last UNK			15. MOTHER'S MAIDEN NAME First Middle Last UNK						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16b. SOCIAL SECURITY NO. 579603875		17. INFORMANT Jerome D. Allen		ADDRESS 11101 Belton St. Md		
18. CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Insufficiency DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 42									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18.)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No		City or Town		County	State
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE Beldon R. Reap M.D.		EXAMINER'S NAME (Type) BELDON R. REAP, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED July 29, 1968	
23a. BURIAL, CREMATION REMOVAL (Specify) Burial		23b. DATE 7/31/1968		23c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery		23d. LOCATION (City or Town) (County) (State) Colmar Manor, Maryland			
24. FUNERAL DIRECTOR Valley Funeral Home Mt. Rainier, Md.				ADDRESS		25a. REC'D BY REG. STRAR AUG 1 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	

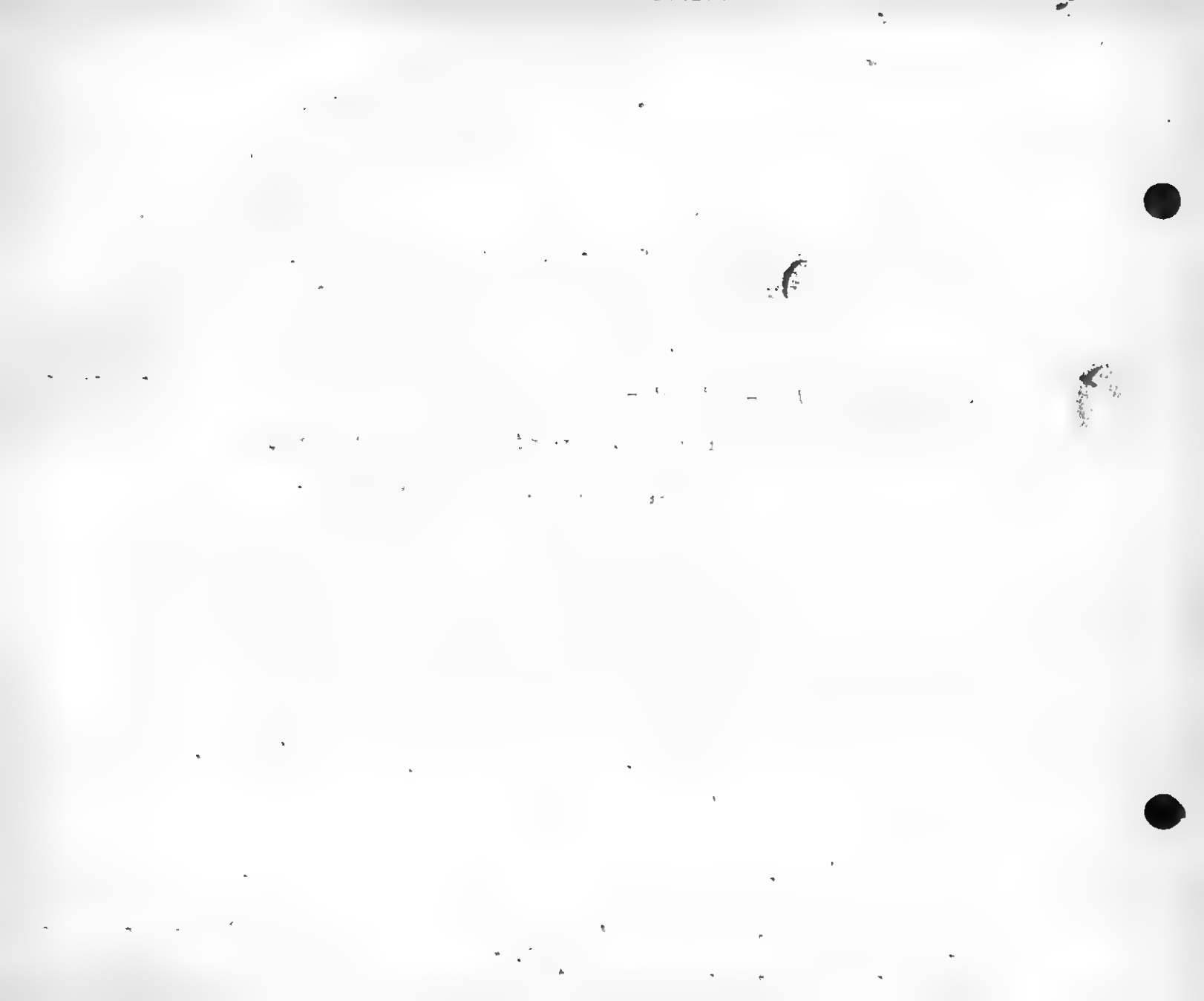
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) First EDWARD Middle B. Last WARNER		2a. DATE OF DEATH July Month 26 Day 1968		2b. HOUR 2:40 AM	
3 SEX Male		4 RACE White		5. DATE OF BIRTH 6/8/08	
7a. BIRTHPLACE (State or foreign country) Penna.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		6. AGE (in years last birthday) 60 YRS.	
7c. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Montgomery Md.			
10 CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Holy Cross Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) waiter	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.		13b. COUNTY Mont.		13c. CITY OR TOWN Silver Spr	
14. FATHER'S NAME First Middle Last Joseph Warner		15 MOTHER'S MAIDEN NAME First Middle Last Mary Ceron			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give year or dates of service) Yes		16b. SOCIAL SECURITY NO 1143-45 126-12-7304		17 INFORMANT 2356 Glenmont Cir Florence Warner-wife	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia acute bilateral 4549 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) encephalomalacia, panetal lobe (c) DUE TO, OR AS A CONSEQUENCE OF PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDIT ON FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from 4-5-68 to 7-26-68, that (I) (we) lost saw the deceased alive on 7-26-68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE John J. Curry		22c. DATE SIGNED 7/26/68		22d. PHYSICIAN'S NAME (Type) John J. Curry	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE July 29 1968		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven	
23d. LOCATION (City or Town) (County) (State) Silver Spring, Mtg. Md.		24. FUNERAL DIRECTOR Carter E. Pumphrey, Inc. Silver Spring, Md.		25a. REC'D BY REGISTRAR JUL 31 1968	
25b. REGISTRAR'S SIGNATURE Charles Judge					



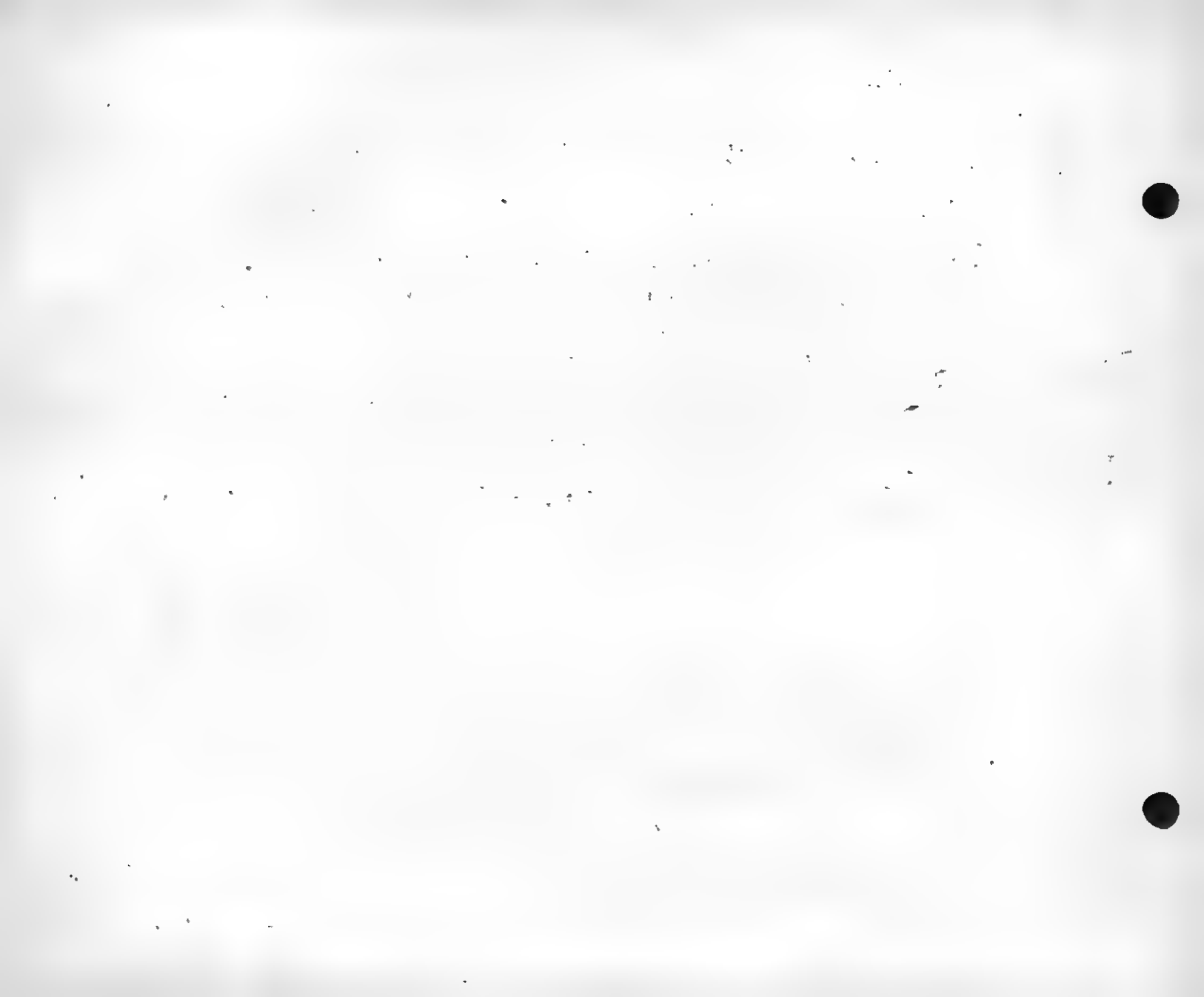
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100879

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) First Middle Last <i>Mary Ellen Weiss</i>			2a. DATE OF DEATH Month Day Year <i>7 24 68</i>			2b. HOUR <i>8 1/2 a.m.</i>	
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>10-27-95</i>		6. AGE (In years lost birthday) <i>72</i> YRS.	
7a. BIRTHPLACE (State or foreign country) <i>Pa.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>Amer</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i> Md.	
10. CITY OR TOWN OF DEATH <i>Takoma Park</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Wash. San. + Hosp.</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE <i>md</i>		13b. COUNTY <i>mont.</i>		13c. CITY OR TOWN <i>Silver Spring</i>		13d. INS. DE. CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER <i>2213 Shorefield Rd.</i>		14. FATHER'S NAME First Middle Last <i>John Reigle</i>		15. MOTHER'S M maiden name First Middle Last <i>Amanda Hoover</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)		16b. SOCIAL SECURITY NO <i>102-40-8278</i>		17. INFORMANT <i>Hospital Record</i>		Address	
18. CAUSE OF DEATH (Enter only one cause per one for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>CEREBRO-VASCULAR ACCIDENT</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>CARCINOMA, CERVIX, WITH METASTASES</i> ? 1 yr. DUE TO, OR AS A CONSEQUENCE OF (c) <i></i>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 DAYS</i>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <i>201X</i>							
19a. DATE OF OPERATION <i>—</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>—</i>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year <i>19</i> P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <i>7-12</i> , 19 <i>68</i> , to <i>7-24</i> , 19 <i>68</i> , that (I) (we) lost saw the deceased alive on <i>7-22</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) view the body after death.							
22b. SIGNATURE <i>Dwight R. Smith M.D.</i>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>7-24-68</i>	
22d. PHYSICIAN'S NAME (Type) <i>DWIGHT R. SMITH</i>				22e. ADDRESS <i>800 PERSHING DR. SILVER SPRING, MD</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		23b. DATE <i>27 JULY 1968</i>		23c. NAME OF CEMETERY OR CREMATORY <i>UNION CEMETERY</i>		23d. LOCATION (City or Town) (County) (State) <i>GRATZ DOLPHIN PENN.</i>	
24. FUNERAL DIRECTOR <i>J. Arthur Walters, 254 Carroll St. N.W. W.C.</i>				25a. REC'D BY REGISTRAR <i>JUL 29 1968</i>		25b. REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) <div style="display: flex; justify-content: space-between;">VeraIsabelWhalen</div>			2a. DATE OF DEATH Month <u>July</u> Day <u>30</u> Year <u>1968</u>			2b. HOUR <u>6:10 P.M.</u>			
3. SEX Female		4. RACE White		5. DATE OF BIRTH July 7, 1892		6. AGE (In years last birthday) 76 YRS.		7. UNDER YEAR MONTHS <u> </u> DAYS <u> </u> HOURS <u> </u> MIN. <u> </u>	
7a. BIRTHPLACE (State or foreign country) Wash., D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.			
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 8613 Piney Branch Rd.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Takoma Park		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 8614 Garland Ave.	
14. FATHER'S NAME First Middle Last Alexander M. Cole			15. MOTHER'S MAIDEN NAME First Middle Last Annie M. Denty						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b. SOCIAL SECURITY NO 220-50-5971		17. INFORMANT APM, Mark A. Whalen		Address Quarters #1 Governor's Island N.Y.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarct</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary artery Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Atherosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>4109</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>20 min</u> <u>years</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>2201</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. <u> </u> Month <u> </u> Day <u> </u> Year <u>19</u> P.M. <u> </u>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or RFD No. City or Town County State				
22a. I certify that (1) (this hospital) attended the deceased from <u>July 25, 1968</u> to <u>July 30, 1968</u> , that (1) (we) last saw the deceased alive on <u>July 30, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>John L. Ford MD</u> DEGREE					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>July 30 1968</u>		
22d. PHYSICIAN'S NAME (Type) John L. Ford M.D.					22e. ADDRESS 831 University Blvd. E. Sil.Spr., Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE Aug. 2, 1968		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven		23d. LOCATION (City or Town) (County) (State) Silver Spring Md.			
24. FUNERAL DIRECTOR <u>Francis J. Collins</u> ADDRESS 3821 14th St., N. W. Wash., D. C.					25a. REC'D BY REGISTRAR AUG 1 1968		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

Montgomery

1 n.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

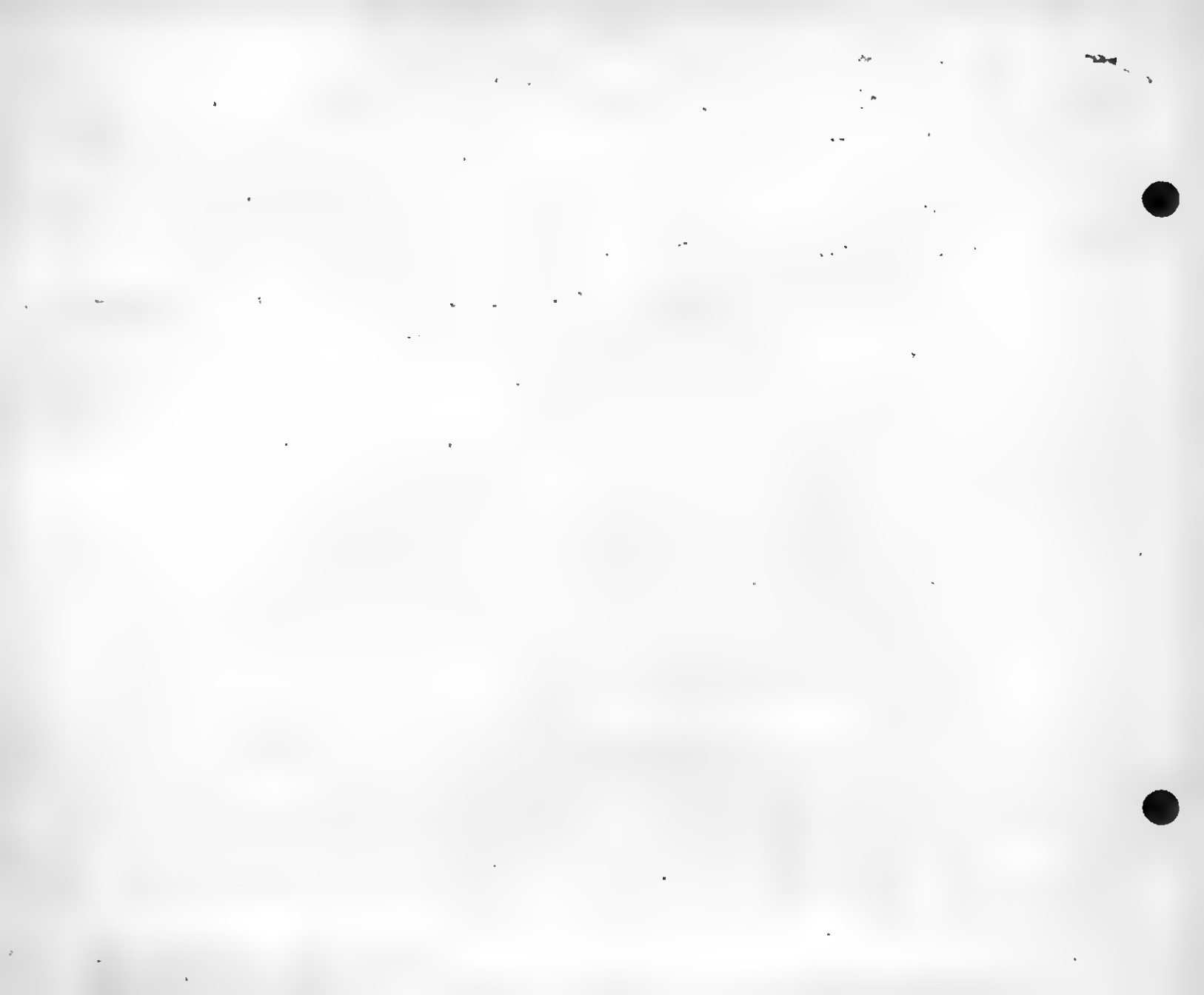
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print) <i>William</i>		First Middle Last <i>Wheary</i>		2a. DATE OF DEATH 7 Month 8 Day Year <i>68</i>		2b. HOUR <i>7:10</i> M	
3 SEX <i>Male</i>		4 RACE <i>White</i>		5. DATE OF BIRTH <i>Jan. 14, 1904</i>		6 AGE (In years lost birthday) <i>64</i> YRS	
7a. BIRTHPLACE (State or foreign country) <i>Virginia</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i> Md.	
10. CITY OR TOWN OF DEATH <i>Bethesda</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Contractor</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Building</i>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md.</i>		13b. COUNTY <i>Mont.</i>		13c. CITY OR TOWN <i>Bethesda</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER <i>7706 Whitier Blvd</i>		14. FATHER'S NAME First Middle Last <i>JAMES Wheary</i>		15. MOTHER'S MAIDEN NAME First Middle Last <i>Hattie</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i>		16b. SOCIAL SECURITY NO <i>578-24-4680</i>		17. INFORMANT Address <i>ELAINA WHEARY (Wife) SAME AS #13</i>			
18. CAUSE OF DEATH (Enter only one cause per Part 1. Death was CAUSED BY IMMEDIATE CAUSE (a) <i>Coronary thrombosis</i> 4104 DUE TO, OR AS A CONSEQUENCE OF <i>arteriosclerosis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>arteriosclerosis</i> DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 hrs</i>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>1. Stroke 2. Generalized arteriosclerosis</i>							
9a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <i>1/2/68</i> , 19__, to <i>7/2/68</i> , 19__, that (I) (we) lost saw the deceased alive on <i>7/2/68</i> , 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Patrik Jameson</i> DEGREE				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>7/7/68</i>	
22d. PHYSICIAN'S NAME (Type) <i>Patrik JAMESON</i>				22e. ADDRESS <i>11718 Ga. Ave Silver Spring Md</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>July 10 1968</i>		23c. NAME OF CEMETERY OR CREMATORY <i>WASH NAT. Cem.</i>		23d. LOCATION (City or Town) (County) (State) <i>SUITLAND MD.</i>	
24. FUNERAL DIRECTOR <i>W. W. CHAMBERS CO.</i>		ADDRESS <i>Silver Spring Md. C.</i>		25a. REC'D BY REGISTRAR <i>JUL 10 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



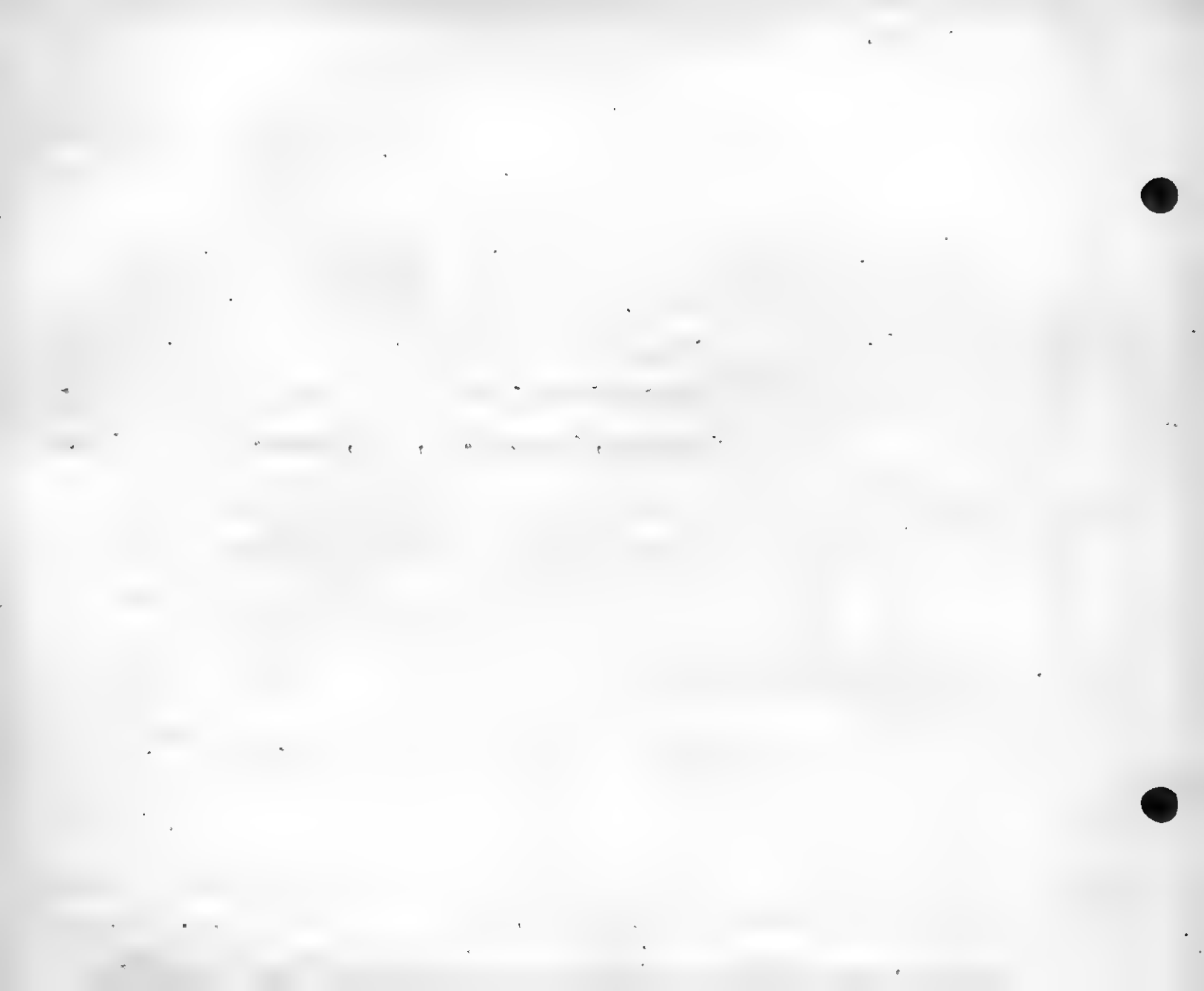
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR 10-1
30M REV. 1-58

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

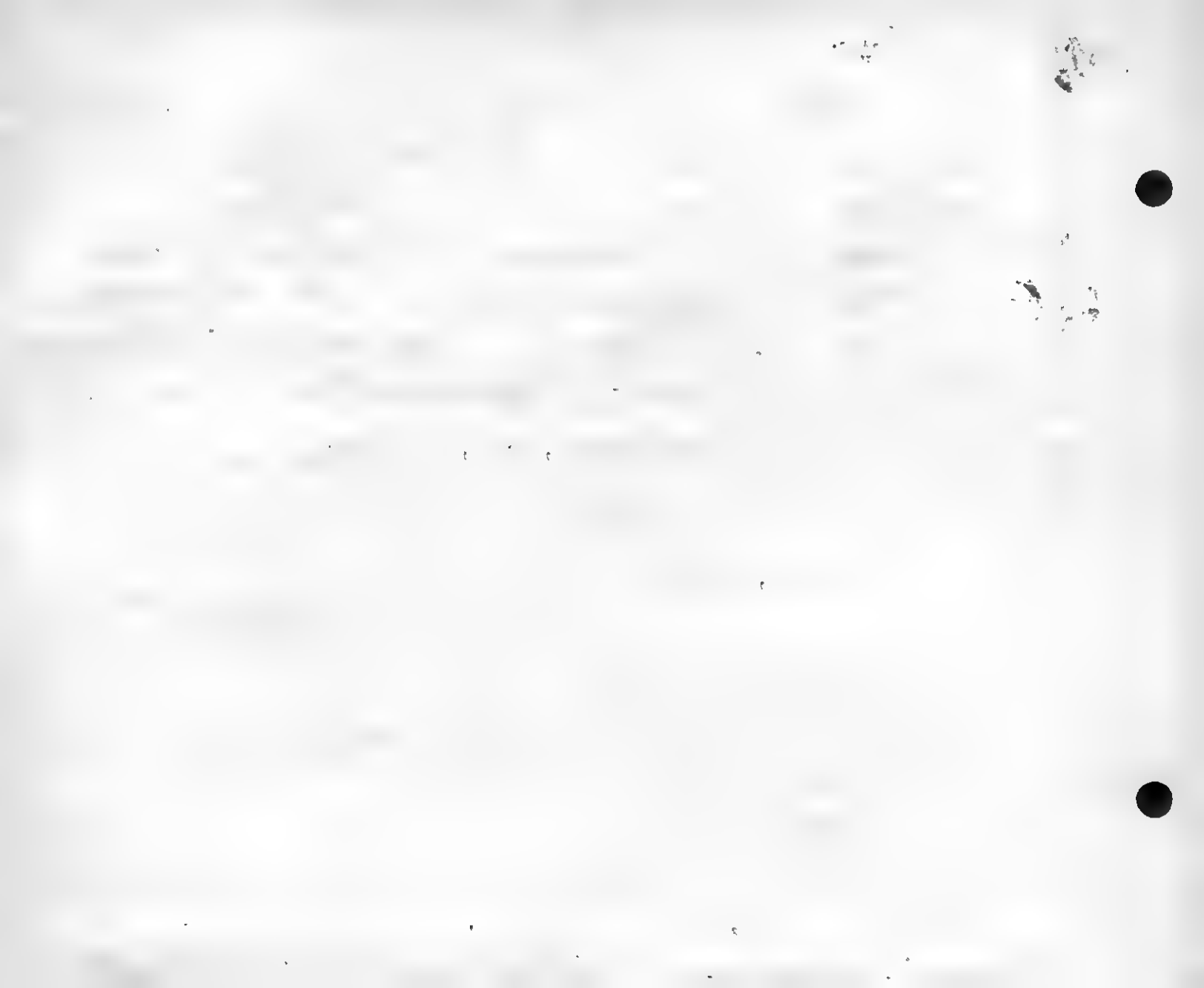
1 DECEASED NAME (Type or print) DONALD MANLY WILLIAMS			2a. DATE OF DEATH Month July Day 8 Year 1968			2b. HOUR 2:15 P M											
3 SEX MALE		4 RACE WHITE		5 DATE OF BIRTH 10/12/1911		6 AGE (in years last birthday) 56 YRS.		7 UNDER YEAR MONTHS 5		8 UNDER 24 HRS. DAYS 10		9 UNDER 24 HRS. HOURS 2		10 UNDER 24 HRS. MIN. 15			
7a. BIRTHPLACE (State or foreign country) Missouri			7b. CITIZEN OF WHAT COUNTRY? U.S.A			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH MONTGOMERY Md.								
10 CITY OR TOWN OF DEATH BETHESDA			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SUBURBAN			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) PROFESSOR			12b. KIND OF BUSINESS OR INDUSTRY American Univ								
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND			13b. COUNTY MONTGOMERY			13c. CITY OR TOWN BETHESDA			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER 5713 Roosevelt St					
14. FATHER'S NAME First FRED Middle WILLIAMS Last WILLIAMS			15 MOTHER'S MAIDEN NAME First KATHERINE R. Middle MANLY Last MANLY														
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, No, or unknown? NO (If yes give year or dates of service) ****			16b. SOCIAL SECURITY NO 548-28-8726			17 INFORMANT Address Josephine Williams - WIFE - SAME											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage, intracerebral, left, massive 4319 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)				21f. LOCATION Street or R.F.D. No. City or Town County State											
22a. I certify that (I) (this hospital) attended the deceased from July 6, 1968 , to July 8, 1968 , that (I) (we) last saw the deceased alive on July 8, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.																	
22b. SIGNATURE Sidney J. Cohen, M.D.		M.D. DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED July 9, 1968							
22d. PHYSICIAN'S NAME (Type) Sidney J. Cohen, M.D.		22e. ADDRESS 50 W. Adamston Rd., Rockville, Md.															
23a. BURIAL, CREMATION, REMOVAL, SPECIES CREMATION		23b. DATE 7/10/68		23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CREMATORY				23d. LOCATION (City or Town) (County) (State) SUITLAND, PR. GEO. MD.									
24 FUNERAL DIRECTOR ROBERT A. PUMPHREY FUNERAL HOME				BETHESDA, MD.				25a. REC'D BY REGISTRAR JUL 15 1968				25b. REGISTRAR'S SIGNATURE Charles Judge					



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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
103883									
CERTIFICATE OF DEATH									
1 DECEASED-NAME (Type or print)			First Middle Last			2a DATE OF DEATH			2b HOUR
Edward E. Hillier						July 16 1968			6:45 PM
3. SEX		4 RACE		5 DATE OF BIRTH		6 AGE in years (lost birthday)		7 UNDER 24 HRS. MONTHS DAYS HOURS MIN	
male		white		6-25-06		62 YRS.			
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md	
Maryland		USA				Montgomery			
10. CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b KIND OF BUSINESS OR INDUSTRY			
Bethesda		Suburban		Electrician -		EBM			
13a USUAL RESIDENCE (Where deceased admission) STATE		13b. COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIM 15? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER	
Maryland		Montgomery		Silver Spring				10222 Calverville Road	
14 FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
Edward C. Hillier			Mary C. Anderson						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)		16b SOCIAL SECURITY NO.		17 INFORMANT		Address			
No		214-10-1629		Dr. James Edward Hillier - (Dr.)					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Peritonitis, acute, due to perforated duodenal ulcer</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Scleroderma</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL, BETWEEN ONSET AND DEATH <u>2-3 days</u> <u>2-3 years</u>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>5411 Scleroderma, diffuse type</u>									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTR BUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC)		21f LOCATION Street or R.F.D. No		City or Town		County State	
22a I certify that (I) (this hospital) attended the deceased from <u>1 July</u> , 19 <u>68</u> , to <u>16 July</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>16 July</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE <u>Eugene P. Libre MD</u>					22c. DATE SIGNED <u>17 July 1968</u>				
22d. PHYSICIAN'S NAME (Type) <u>EUGENE P. LIBRE</u>					22e ADDRESS <u>10400 Conn. Ave. N.W.</u>				
23a BURIAL CREMATION REMOVAL (Specify)		23b. DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)			
Burial		July 19, 1968		Smithburg, Md.		Smithburg, Md.			
24 FUNERAL DIRECTOR <u>Warner E. Pumphrey, Inc.</u>					25a REC'D BY REGISTRAR <u>JUL 23 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		



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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) Rev. James T. WILSON			2a. DATE OF DEATH Month 7 Day 12 Year 68			2b. HOUR 1 1/2 M				
3. SEX male		4. RACE white		5. DATE OF BIRTH 8-5-1898		6. AGE (in years last birthday) 69 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (State or foreign country) N. Carolina		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.				
10. CITY OR TOWN OF DEATH Wheaton, Md.		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Randolph Hills		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Pastor		12b. KIND OF BUSINESS OR INDUSTRY				
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission). STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 107 Mallon		
14. FATHER'S NAME First Howard Middle Wilson Last Wilson			15. MOTHER'S MAIDEN NAME First MARY Middle GREEN Last GREEN							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown No (If yes give war or dates of service)			16b. SOCIAL SECURITY NO 214-14-6978		17. INFORMANT Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) BRONCHO PNEUMONIA 485 X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 13 DAYS										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) CEREBRAL ARTERIOSCLEROSIS, PARKINSONISM, CIRRHOSIS, LIVER PORTAL HYPERTENSION, CHOLELITHIASIS										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from 7/11 19 68 , to 7/12 19 68 , that (I) (was) last saw the deceased alive on 7/11 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE David Goldenberg				DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 7/12/68				
22d. PHYSICIAN'S NAME (Type) DAVID GOLDENBERG				22e. ADDRESS 7801 GEORGETOWN SPRING, Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 7-15-68		23c. NAME OF CEMETERY OR CREMATORY Good Shepherd		23d. LOCATION (City or Town) (County) (State) Elliot City, Md.				
24. FUNERAL DIRECTOR 1414 North Howard St.		ADDRESS Elliot City, Md.		25a. REC'D BY REGISTRAR JUL 16 1968		25b. REGISTRAR'S SIGNATURE Charles Judge				



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

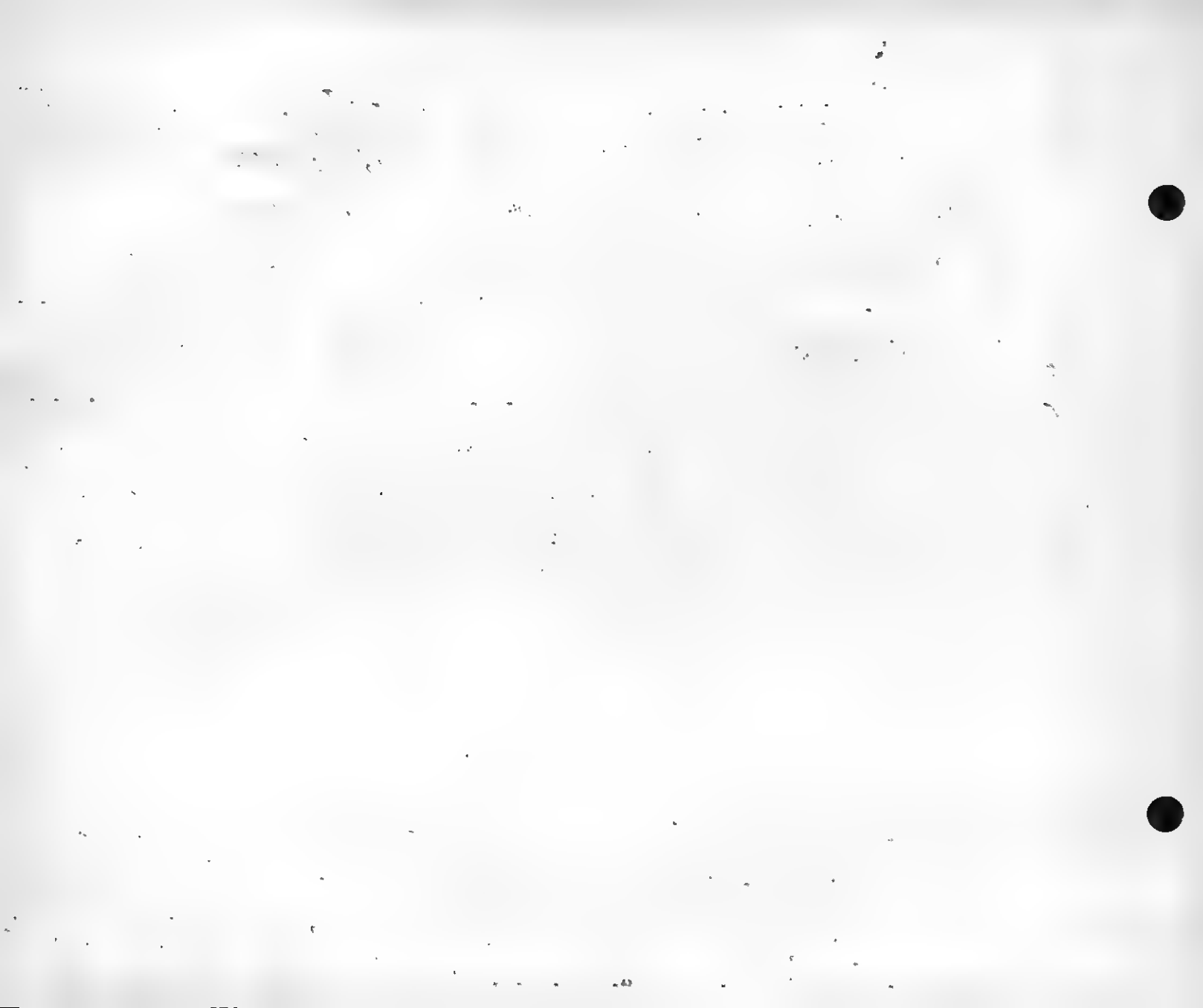
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1 DECEASED NAME (Type or Print)			First		Middle		Last		2a DATE KNOWN OF ESTI- DEATH MATED		2b HOUR
Joseph			Mock		Windsor				Month Day Year		6:10 P.M.
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		2c DATE PRONOUNCED DEAD		2d HOUR	
Male	White	9-30-18	49 YRS					Month Day Year		6:30 P.M.	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. COUNTY OF DEATH					
Md.		U.S.A.		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Montgomery					
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY		
Silver Spring			Holy Cross Hos.			Electrician Technician			Electrical		
13a USUAL RESIDENCE (Where deceased lived, if institution on admission) STATE			13b COUNTY		13c CITY OR TOWN		3a INSIDE CITY LIMITS?		13b STREET AND NUMBER		
Md.			Montgomery		Silver Spr.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		12310 Viers Mill Rd.		
14 FATHER'S NAME			First		Middle		Last		15 MOTHER'S MAIDEN NAME		First Middle Last
Jessie			Windsor		Gertrude		Duvall				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SECURITY NO		17. INFORMANT		13310 ADDRESS				
Yes			Army W.W.II		Patty R. Windsor		Silver Spring, Md.				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Insufficiency Acute.</u>										Sudden.	
4119 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last											
(b) DUE TO, OR AS A CONSEQUENCE OF											
(c) DUE TO, OR AS A CONSEQUENCE OF											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
4201											
19a DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?			
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>			21b TIME OF INJURY Month, Day, Year			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
CAUSE OF DEATH			HOUR A.M. P.M.			19					
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f LOCATION Street or R.F.D. No			City or Town County State		
22a I certify that I took charge of the remains described above, held on death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
22a Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion											
ACTUAL SIGNATURE			John G. Ball			M.D.			22b DATE SIGNED		
EXAMINER'S NAME (Type)			John G. Ball			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			July 3, 1968		
						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
						ADDRESS (Street, city, town, or county)					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b DATE		23c NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)			
Burial			July 6, 1968		Parklawn Cemetery			Kochville, Maryland			
Funeral Director			C. Glen Carter			4334 Georgia Avenue			25a. REC'D BY REGISTRAR		
John C. Humphrey, Inc.			Silver Spring, Md.			JUL - 8 1968			25b. REGISTRAR'S SIGNATURE		
									Charles Judge		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the hospital director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1 DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR		
GERTRUDE			MID			WINKLER			JULY 26 1968 12:35 PM		
3. SEX		4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		7 UNDER YEAR		8 UNDER 24 HRS	
FEMALE		WHITE		MAY 17 1884		81 YRS		MONTHS		DAYS	
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH		
GERMANY			U.S.A.			MONTGOMERY			Md.		
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Kensington			Kensington Gardens Sanitarium			Housewife			Own Home		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INS DE CITY LIMITS?		
Md.			Montgomery			Silver Spring			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			13e. STREET AND NUMBER			13f. STREET AND NUMBER		
Joseph Schilling			Margaret Pauline Kelfisch			407 Pershing Drive S.S.			407 Pershing Drive S.S.		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)			16b. SOCIAL SECURITY NO			17 INFORMANT			17b. ADDRESS		
No			578-01-449			Mr. H. Martin Winkler			407 Pershing Dr. S.S.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) Pulmonary edema, acute										15 minutes	
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										1 hour	
(b) Congestive heart failure											
DUE TO, OR AS A CONSEQUENCE OF											
(c) Interstitial heart disease										3 years	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
Pulmonary embolism											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
			HOUR A.M. Month Day Year P.M. 19								
21d. INJURY OCCURRED			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION			21g. CITY OR TOWN		
While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>						Street or R.F.D. No.			City or Town		
						County			State		
22a. I certify that (I) (this hospital) attended the deceased from March 1965, to July 26, 1968, that (I) (we) last saw the deceased alive on July 21, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE						22c. DATE SIGNED			22d. PHYSICIAN'S NAME (Type)		
Search T. Kimble MD						7-26-68			Search T. Kimble		
22e. ADDRESS						22f. ADDRESS					
9801 Georgia Ave, Silver Spring Md						9801 Georgia Ave, Silver Spring Md					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
Burial			July 29, 1968			Prospect Hill Cemetery			Washington, District of Col.		
24 FUNERAL DIRECTOR			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE			25c. DATE		
C. Glen Carter Warner E. Pumphrey Inc. 8434 Ga. Ave. S.S., Md			JUL 31 1968			J. Charles Judge			JUL 31 1968		

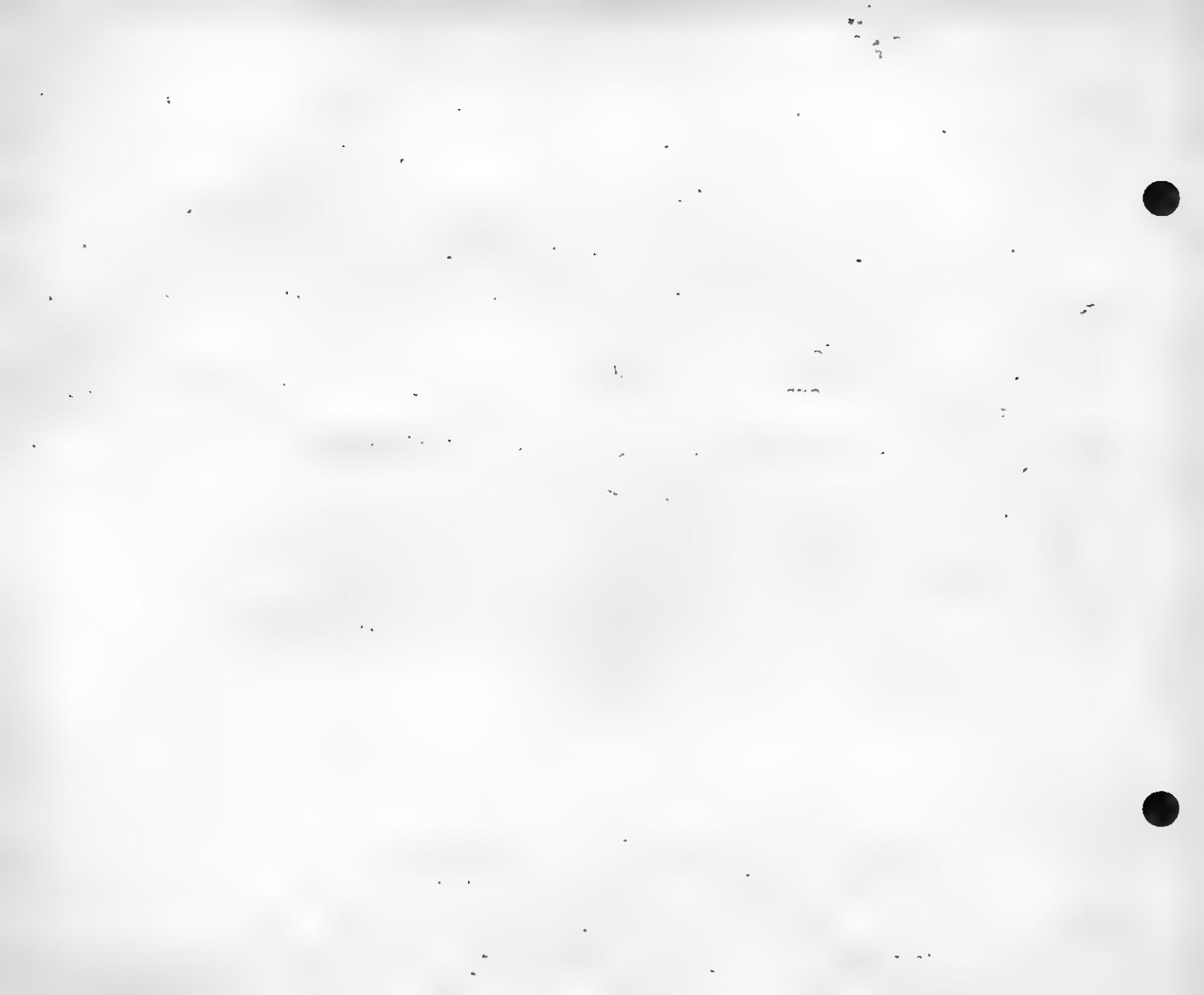


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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Collected. week next to funeral

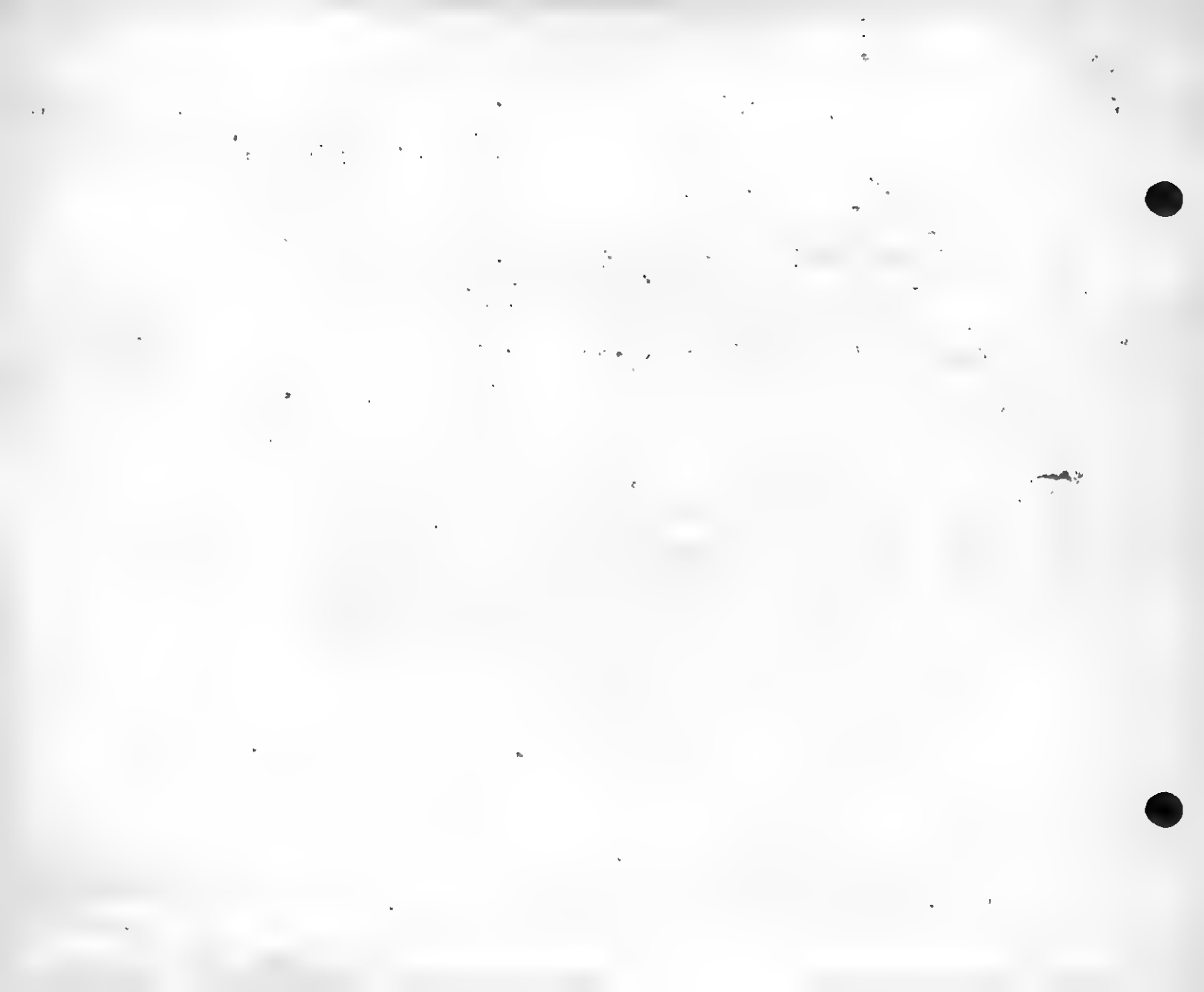
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED NAME (Type or print) MARGARET (MRS)			First Middle Last			2a. DATE OF DEATH 7 Month 22 Day 68 Year		2b. HOUR 9A. M.	
3 SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH 15 JULY, 1887		6 AGE (In years last birthday) 81 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH MONTGOMERY Md.			
10 CITY OR TOWN OF DEATH SILVER SPRING		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 10120 New Hampshire Ave.		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b KIND OF BUSINESS OR INDUSTRY own home			
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD		13b. COUNTY MONT.		13c. CITY OR TOWN SILVER SPRING		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 10120 New Hampshire Ave.	
14. FATHER'S NAME First Middle Last William Webster			15 MOTHER'S MAIDEN NAME First Middle Last Mary Stansbury			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) no (If yes give war or dates of service)			
16b SOCIAL SECURITY NO 579-xxx-7149			17 INFORMANT William J. Sturgeon			Address 10323 Geranium Ave. Md.			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) ACUTE CORONARY THROMBOSIS 4/1/68 DUE TO, OR AS A CONSEQUENCE OF (b) ATHEROSCLEROTIC HEART DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) HEART DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH INSTANT YEARS	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) None									
19a. DATE OF OPERATION ---		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED ---		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME FARM STREET FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 1957 to 22 July , 19 68 , that (I) (we) lost saw the deceased alive on 4 April 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE W. Howard Yeager, Jr.				DEGREE P.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c DATE SIGNED 7/22/68	
22d. PHYSICIAN'S NAME (Type) W. Howard Yeager, Jr.				22e ADDRESS 1808 Conn Ave N.W., Wash. D.C.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE July 26, 1968		23c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery		23d. LOCATION (City or Town) (County) (State) Arlington, Virginia			
24. FUNERAL DIRECTOR Warner E. Humphrey, Inc.				ADDRESS 8434 Georgia Ave. Silver Spring, Md.		25a. REC'D BY REGISTRAR JUL 29 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	



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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
Item 2a Film G405 10/1/68 12											
CERTIFICATE OF DEATH											
1 DECEASED NAME (Type or print) First Middle Last MARGARET LILLIAN WOOD						2a DATE OF DEATH Month Day Year July 19 1968 1968			2b HOUR 10:10 PM		
3. SEX FEMALE		4. RACE WHITE		5 DATE OF BIRTH JAN 16 1888		6 AGE (In years last birthday) 80 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a BIRTHPLACE (State or foreign country) Ohio		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH MONTGOMERY Md.					
10 CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Washington Sant Hosp		12a USUA. OCCUPATION (Kind of work done during most of work life, even if retired) Cook		12b KIND OF BUSINESS OR INDUSTRY Unk					
13a USUA. RES DENCE (Where deceased lived, if institution: Res dence before admission) - STATE DC.				13b COUNTY Washington		13c CITY OR TOWN Washington		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 304-12 St. N.E.	
14 FATHER'S NAME First Middle Last ELIJAH unknown James				15 MOTHER'S MAIDEN NAME First Middle Last Margaret - Cooley							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) No				16b. SOCIAL SECURITY NO. unknown		17 INFORMANT Hospital Records Address					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) acute congestive failure 4120 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) hypertensive cardiac disease DUE TO, OR AS A CONSEQUENCE OF (c) arteriosclerosis										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days unknown	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Diabetes mellitus											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) at work		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from Jan 1, 1968 to July 19, 1968 , that (I) (we) last saw the deceased alive on July 18, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE H. S. Hadley		DEGREE M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED July 20 68					
22d. PHYSICIAN'S NAME (Type) H. S. HADLEY MD		22e. ADDRESS 4601 NICHOLS AVE SW									
23a. BURIAL, CREMATION, REMOVAL (Specify) 7-23-68		23b. DATE 7-23-68		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City or Town) (County) (State) Arlington Virginia					
24. FUNERAL DIRECTOR W. W. Chambers & Co. 517-11 St. S.E.				25a. REC'D BY REGISTRAR JUL 23 1968		25b. REGISTRAR'S SIGNATURE Charles Judge					



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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print) First Middle Last <i>Fannie B. Woods</i>						2a. DATE OF DEATH Month Day Year <i>July 10 1968</i>		2b. HOUR <i>6:05</i>		M	
3. SEX <i>female</i>		4. RACE <i>white</i>		5. DATE OF BIRTH <i>11-9-94</i>		6. AGE (In years last birthday) <i>73</i>		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <i>Michigan U.S.A.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i>					
10. CITY OR TOWN OF DEATH <i>Bethesda</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>private</i>					
13a. USUAL RESIDENCE (Where deceased lived at institution, Residence before admission) STATE <i>MD.</i>		13b. CITY OR TOWN <i>Bethesda</i>		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13d. STREET AND NUMBER <i>Wigwagsville Rd. #100</i>					
14. FATHER'S NAME First Middle Last <i>Andrew J. Smith</i>		15. MOTHER'S MAIDEN NAME First Middle Last <i>Emilee Brunthal</i>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <i>No</i>		16b. SOCIAL SECURITY NO <i>506-08-0182A</i>		17. INFORMANT <i>Phs. Chart</i>		Address					
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH CAUSED BY: IMMEDIATE CAUSE (a) <i>Bacterial pneumonia</i>										<i>2 days</i>	
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Come after brain tumor removal</i>										<i>3 weeks</i>	
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Olfactory groove meningioma</i>										<i>20 years</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION <i>6/10/68</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>BRAIN Tumor Removal</i>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 1B)							
21d. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) <i>at work</i>		21e. PLACE OF INJURY		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <i>6/10</i> , 19 <i>68</i> , to <i>7/10</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>7/10</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>John Thomas Lead</i>		DEGREE <i>MD</i>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>7/10/68</i>					
22d. PHYSICIAN'S NAME (Type) <i>John Thomas Lead</i>		22e. ADDRESS <i>1015 Spring Street Silver Spring, Md.</i>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Buried</i>		23b. DATE <i>July 13, 1968</i>		23c. NAME OF CEMETERY OR CREMATORY <i>National Memorial Park</i>		23d. LOCATION (City or Town) (County) (State) <i>Falls Church, Va.</i>					
24. FUNERAL DIRECTOR <i>John Walters</i>		ADDRESS <i>254 Carroll Park Wash DC</i>		25a. REC'D BY REGISTRAR <i>JUL 15 1968</i>		25b. REGISTRAR'S SIGNATURE <i>John Charles Judge</i>					

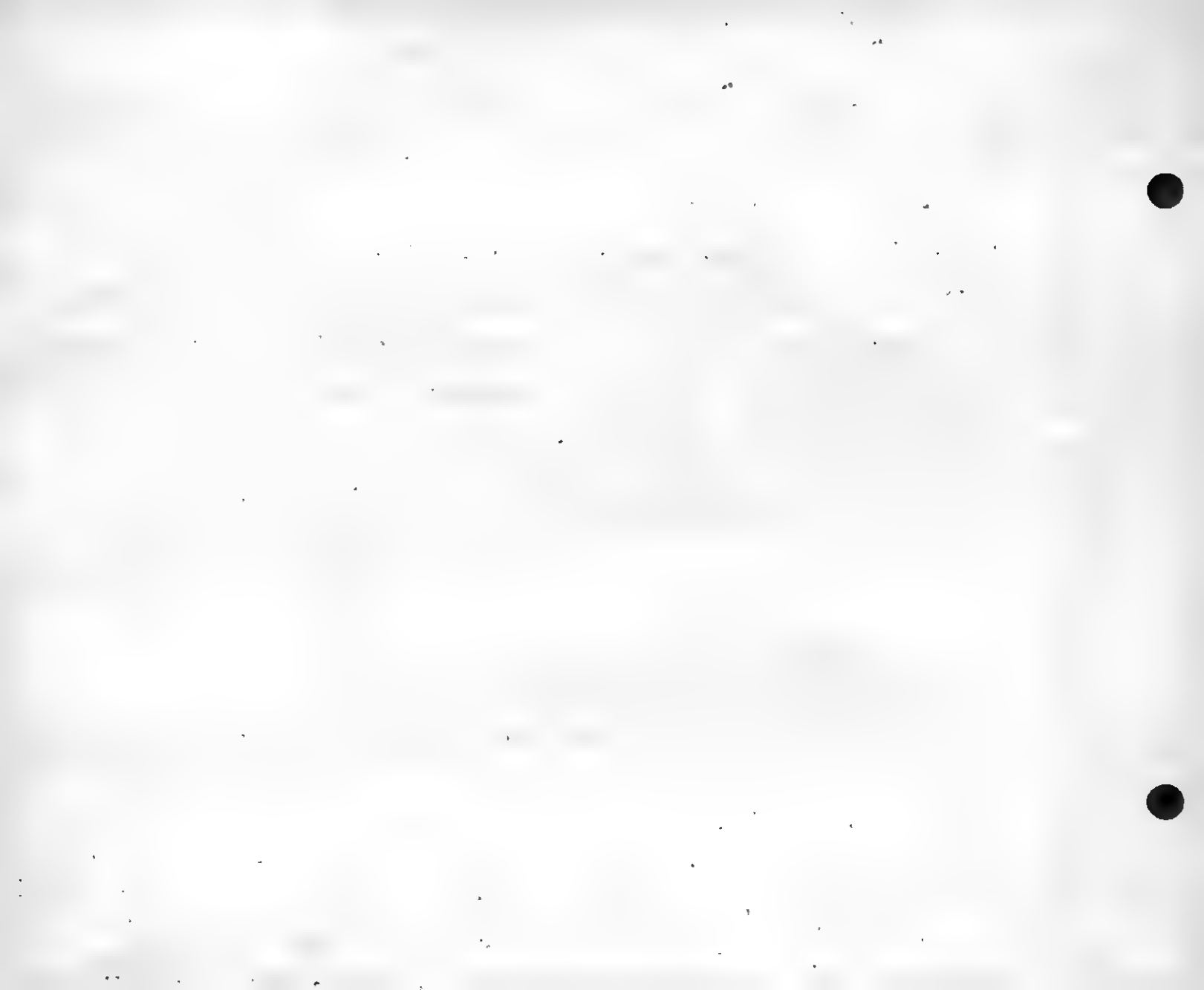


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
Item # 7a,b,15, Film # 402 7/1/68										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print) First Middle Last Rudolf (NMN) Zafft					2a. DATE OF DEATH Month Day Year July 6, 1968			2b. HOUR A.M. P.M. 1:30 M		
3. SEX Male		4. RACE White		5. DATE OF BIRTH June 24, 1968		6. AGE (in years last birthday) 63 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) Russia		7b. CITIZEN OF WHAT COUNTRY? Russian		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.				
10. CITY OR TOWN OF DEATH Takoma Park			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington Sanitarium			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Maintenance		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) STATE Maryland			13b. COUNTY Montgomery		13c. CITY OR TOWN Takoma Park		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 7102 Woodland Avenue	
14. FATHER'S NAME First Middle Last August Zafft			15. MOTHER'S MAIDEN NAME First Middle Last Augustina Erindfleisch							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) no			16b. SOCIAL SECURITY NO. 215-38-6755		17. INFORMANT Patient's chart Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic carcinoma DUE TO, OR AS A CONSEQUENCE OF (b) Carcinoma of stomach Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH. 3 months 15 months		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 14/12										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from 4-8, 1968 , to 7-6, 1968 , that (I) (we) last saw the deceased alive on 7-5, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Eino Magi, M.D. DEGREE					ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 7-6-68			
22d. PHYSICIAN'S NAME (Type) EINO MAGI					22e. ADDRESS 831 University Blvd. E. Silver Spring					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 8-9-1968		23c. NAME OF CEMETERY OR CREMATORY St. Francis		23d. LOCATION (City or Town) (County) (State) Beltsville Md. Md.				
24. FUNERAL DIRECTOR Arthur Waters		25. ADDRESS 254 Broadway St. N.W.		25a. REC'D BY REGISTRAR TUL 10 1968		25b. REGISTRAR'S SIGNATURE John J. Jones				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and 10 days after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED NAME (Type or print) First Middle Last JULIUS ZAWATSKY						2a. DATE OF DEATH Month Day Year 7 20 68			2b. HOUR 5:45 M		
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH 1-15-03		6. AGE (In years last birthday) 65 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) POLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH MONTGOMERY COUNTY Md.					
10. CITY OR TOWN OF DEATH SILVER SPRING		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) HOLY CROSS HOSPT		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) LAUNDRY WORKER		12b. KIND OF BUSINESS OR INDUSTRY LAUNDRY					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD		13b. COUNTY MONT		13c. CITY OR TOWN SILVER SP.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 1400 FENWICK LANE			
14. FATHER'S NAME First Middle Last ABRAHAM ZAWATSKY				15. MOTHER'S MAIDEN NAME First Middle Last ANNA UNK.							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) NO		16b. SOCIAL SECURITY NO. 131-05-1905		17. INFORMANT KENNETH ZAWATSKY 804 STICKLEMANA. MD.				Address POTOMAC			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE MYOCARDIAL FAILURE DUE TO, OR AS A CONSEQUENCE OF (b) PULMONARY CARCINOMA (ADENOCARCINOMA) DUE TO, OR AS A CONSEQUENCE OF (c) WITH METASTASES										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 WEEKS	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 163X											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 68		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from FEB. 1968 , to JULY 20 1968 , that (I) (we) lost the deceased alive on JULY 19 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Robert L. Krichmar		DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED JULY 20 1968					
22d. PHYSICIAN'S NAME (Type) ROBERT L. KRICHMAR MD		22e. ADDRESS 7733 ARASKA AVENUE NW WASHINGTON D.C. 20014									
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 7-22-1968		23c. NAME OF CEMETERY OR CREMATORY VALLEY MEMORIAL PARK FALLS CHURCH VA.		23d. LOCATION (City or Town) (County) (State)					
24. FUNERAL DIRECTOR Gold BEGG Fun Home 4217 - 1st NW		ADDRESS		25a. REC'D BY REGISTRAR JUL 23 1968		25b. REGISTRAR'S SIGNATURE Charles Judge					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)		First		Middle		Last		2a. DATE OF DEATH		2b. HOUR	
BERTHA BOWINS ZEIGLER								July 26 1968		M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years lost birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
FEMALE		NEGRO		7-31-1930		37 YRS.		MONTHS DAYS		HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
		U.S.A				MONTGOMERY				Md.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY					
DAMASCUS		Holsey Road, Her home									
13a. USUAL RESIDENCE (Where deceased admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER			
MD.		MONTG		DAMASCUS				9338 Holsey Road			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME									
First Middle Last		First Middle Last									
Ralph		Bowin		Rachel				Weedon			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO.		17. INFORMANT				Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of breast, generalized metastases</u> 174X DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 170X											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from 6/24, 1968, to 7/20, 1968, that (I) last saw the deceased alive on 7/19, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS					
James P. Kerr M.D.		7/20/68									
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
BURIAL		7-25-68		Friendship Cemetery		DAMASCUS MONTG MD					
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
R. L. Snowden		JUL 29 1968		g Charles Judge							
Rockville Md.											



[Faint, illegible handwritten text, possibly bleed-through from the reverse side of the page.]

